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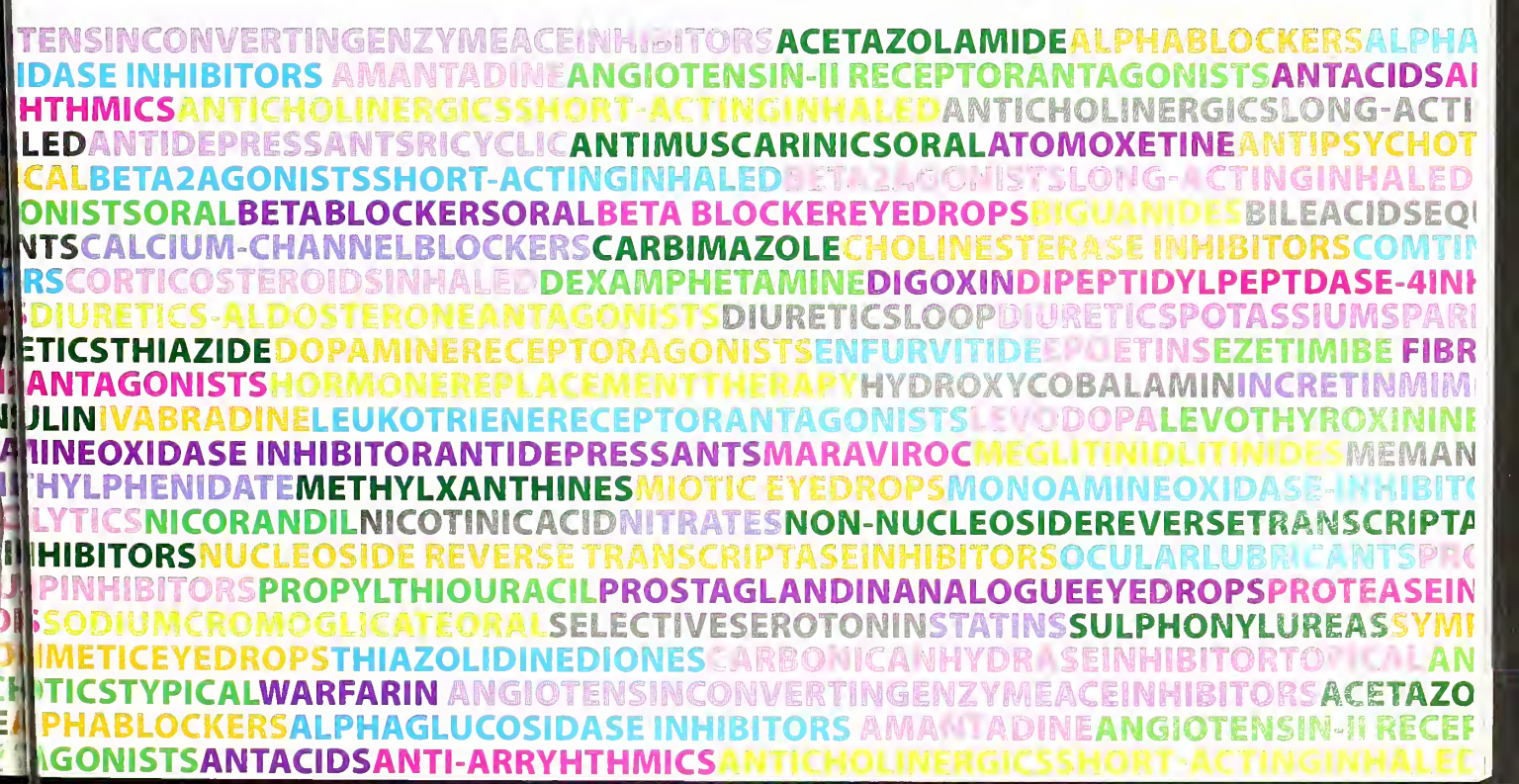
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7 June 2008



D MUR ZONE – THE COMPLETE GUIDE SEE PAGE 26



HIGH POLLEN COUNTERED FAST.

- **Benadryl Allergy Relief contains Acrivastine, which gets to work in just 15 minutes.**
- **The No.1 selling hay fever brand worth £13M.***
- **Supporting you this season with a £4M campaign including TV and press.**

*IRI Market Value Sales; MAT to 23rd February 2008



The fastest acting allergy capsule.

Benadryl Allergy Relief Product Information: Presentation: Acrivastine 8 mg capsules. **Uses:** Allergic rhinitis. Also chronic idiopathic urticaria. **Dosage:** Adults and children aged [illegible] - 65 years: one capsule up to 3 times a day. **Contraindications:** Hypersensitivity to acrivastine or triprolidine. Significant renal impairment. **Precautions:** Caution when engaging in activities which require mental alertness until familiar with response to drug. Concomitant use of acrivastine with alcohol or other CNS depressants may produce additional impairment. Caution when taking with ketoconazole, erythromycin or grapefruit juice. **Pregnancy & lactation:** Not recommended. **Side effects:** Rarely drowsiness. **RRP (ex-VAT):** 12s £3.70, 24s £6.42 **Legal category:** 12s GSL, 24s P. **PL holder:** Pfizer Consumer Healthcare, Walton-on-the-Hill, KT20 7NS. **PL number:** 12s 15513/0128, 24s 15513/0035 **Date of preparation: May 2007.**

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Comment from the Editor

Medicines use reviews (MURs) are unsurprisingly a thorny issue in community pharmacy in England and Wales at the moment.

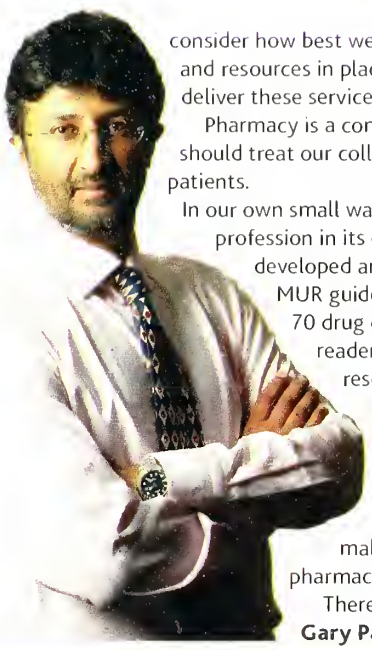
The Pharmacists' Defence Association's finding that some employers could be putting their staff under unfair pressure to meet MUR targets and a study published in the journal Health Policy on the take-up of MURs have helped to ignite the touch paper.

But is there a danger that we may be missing the bigger picture here? As a community, have we not been arguing for years that pharmacists' skills are woefully underutilised? And as we are offered opportunities such as MURs and prescribing, for instance, should we not be looking to take full advantage?

The impact of MURs on patients, pharmacy and the NHS should not be underestimated. The service has led to the introduction of consultation rooms, it has got pharmacists and GPs talking, and it has for the first time resulted in pharmacy receiving a fee for something other than supplying a medicine.

Admittedly, the implementation of MURs has not exactly been smooth. It has required a shift in the sector's mindset and working practices, but it's worth noting that these are issues that even the NHS as a whole struggles with.

So while reports that some pharmacists are being pressurised into meeting targets are wholly unwelcome, we should as a community consider how best we put supporting structures and resources in place to encourage everyone to deliver these services.



Pharmacy is a compassionate profession and we should treat our colleagues as we would our patients.

In our own small way, C+D is supporting the profession in its drive to deliver MURs. We have developed an MUR resource with sample MUR guides for over 20 conditions and 70 drug classes. Mostly written by C+D readers, we hope it proves a useful resource when carrying out MURs.

Each guide on C+D's MUR Zone is intended to be a 'living document' and you are encouraged to contribute your own tips and suggestions to make it even more useful for the pharmacy community as a whole.

There are more details on page 26.

Gary Paragpuri, Editor

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Scotland set for services boost

Additional national public health role expected to be announced within the week

Jennifer Richardson

Scottish pharmacists look set to gain additional national public health services as part of 2008-09 contract arrangements, C+D understands.

Community Pharmacy Scotland expects to announce the outcome of funding negotiations within the week, spokesperson Alex MacKinnon said.

And it is hoped the announcements will also include the addition of national services to the public health service (PHS) element of the contract. CPS has previously lobbied for national services in smoking cessation, the provision of emergency hormonal contraception and chlamydia testing and treatment.

Some details of the remuneration package had yet to be finalised, Mr MacKinnon said. But on the PHS developments, principal pharmacist Alison Strath said: "I'm pretty sure it's all going to go through."

Public health minister Shona Robison revealed the Scottish Government's commitment to a national pharmacy smoking cessation service when announcing the Scottish Government's Smoking Prevention Action Plan in Parliament two weeks ago.

She said: "We are working with community pharmacists across Scotland to provide a national smoking cessation service as part of the public health service element of the new contract."

The Scottish Government has released a series of NHS board funding updates for 2008-09:

- £300,000 will allow pharmacy champions to continue to support contractors in implementing the contract.
- Funding is available for the establishment of supplementary and independent prescribing clinics by pharmacists who have not previously applied, alongside continuing funding for clinics established in 2007-08. Any changes to the set-up and weekly payments of £750 and £150 as part of ongoing contract negotiations will be backdated to April 1.
- A non-recurring allocation of £200,000 will allow the continuation of palliative care model schemes. The SG has committed to considering future arrangements for the schemes and their integration with the contract.

http://tinyurl.com/4b3hhg

C+D online MUR toolkit

C+D has launched an online medicines use review toolkit to aid pharmacists carrying out the advanced service (see p26).

The MUR Zone, which is at www.chemistanddruggist.co.uk/murzone, has MUR tips listed by 20 conditions and 70 drug classes, with more to be added. Beginners are also catered for, with guides to setting up the service and conducting a first MUR.

User comments posted on the guides will be regularly reviewed by C+D's clinical editors so that helpful additional points can be added.

C+D editor Gary Paragpuri said: "This is a valuable tool for the pharmacy community and we hope our readers will use it as a forum to share best practice."

To be alerted when new guides for additional diseases and drugs are available, sign up for the C+D clinical newsletter at www.chemistanddruggist.co.uk/register. **JR**

MUR ZONE

Society needs 30% support to succeed

The RPSGB needs the support of 30 per cent of the profession to ensure the success of a future professional leadership body.

That is the proportion of current members needed to join the body to give it "credibility" once membership is voluntary, according to immediate past president Hemant Patel.

Financial viability was a less crucial factor because the body's structure and offering could vary according to membership levels, the income from which would be supported by publishing, he argued.

"The organisation will continue to exist but what it is able to offer will depend on the two income streams – the publications and the membership," Mr Patel said. "But obviously you need some [membership level] for credibility purposes; my guess is that is 30-50 per cent." However, the Society "must aim to recruit everybody back", Mr Patel urged. **JR**

Hemant Patel: the interview **p12**

Churton named president



Steve Churton, head of professional practice at Boots, has been elected president of the RPSGB's Council.

Mr Churton secured 13 votes to Gerald Alexander's 12 votes, after the second round of voting. There was no clear winner after the initial vote, in which Brian Curwain also stood.

Mr Churton said: "Pharmacy is undergoing seismic change and the landscape in which we currently operate is likely to be unrecognisable in the not too distant future."

Both the vice-president, Martin Astbury, and the treasurer, Andew Gush, were re-elected. **ZS**

2009 retention fee proposals

The RPSGB has proposed an increase in retention fees for practising pharmacists of either 3.9 or 4.5 per cent for 2009.

The choice between the two levels is dependent on proposals to reduce fees for pharmacists with annual incomes of less than £16,500.

Members have 60 days in which to respond to the proposals via the Society's website – www.rpsgb.org.

The most recent Retail Price Index inflation rate recorded by the Office for National Statistics was 4.2 per cent. **JR**

Novartis picks AAH and UniChem in supply deal

Discounts under the microscope, say the two appointed wholesalers

Zoe Smeaton

Novartis has announced a distribution deal to deliver medicines exclusively through UniChem and AAH. Both wholesalers said they were looking into the discount structure for pharmacists.

Mark James, group managing director of AAH, said the model would allow competition between the two wholesale partners. He said AAH would be contacting customers over the next few weeks to discuss the new discount structure. UniChem also confirmed it was "developing" its discount structure on Novartis UK products.

Novartis said its investment into distribution and discounts would remain the same.

The two wholesalers already distribute over 80 per cent of Novartis medicines and a spokesperson for the manufacturer said: "For the vast majority of our customers, there will be no change in the way they order Novartis UK medicines."

The manufacturer said the deal would enable them to operate more efficiently. And Ian Ball, director of commercial operations at Novartis, said as the market had already "consolidated", with two wholesalers already distributing most of the medicines, he hoped the deal would not affect the wholesale market.

John Davies, retail services director of wholesaler Mawdsleys, said the deal could "further erode the reliability of the supply chain" by relying on only two very large organisations.

Paul Smith, CEO at wholesaler Phoenix, said the deal was disappointing: "We've had a good working relationship for many years and as a result would have expected a longer notice period."

The new arrangement will come in on August 4 throughout the UK, including Northern Ireland.

Wholesale market under threat



Richard Barker: economic pressure causing firms to examine supply

The pharmaceutical wholesale market could face an uncertain future if manufacturers continue to sign distribution deals with only the larger operators, European experts have warned.

Speaking at the annual general meeting of the European Association of Pharmaceutical Full-line Wholesalers (GIRP), Richard Barker, director-general of the Association of the British Pharmaceutical Industry, predicted more manufacturers would be striking distribution deals.

Dr Barker said economic pressure and a rise in counterfeiting were causing the companies to examine supply.

GIRP president René Jenny warned that if such deals "creamed off" margins for wholesalers on higher priced products, they would face problems funding distribution of lower priced generics.

He said: "This is our point of fear. We have to live with the market, that's clear, but we have to propose alternatives and other ways to continue to supply medicines, such as providing extra services."

UK wholesalers also expressed concern over the effect such deals could have on competition, and called upon the government to take action.

John Davies, retail services director of wholesaler Mawdsleys, warned a rise in deals with larger wholesalers could lead to "a lack of competition in the marketplace, which by now ought to be worrying the Department of Health very much".

Liam FitzGerald, CEO of United Drug, a wholesaler in Ireland, said changes would mean less choice for pharmacists. **ZS**

Awareness of EHC ethics rights needed

The RPSGB is considering ways to support pharmacists who do not want to provide particular services due to personal beliefs.

The decision came after a Manchester pharmacist was criticised for refusing to supply emergency contraceptives. The Society's Code of Ethics also came under fire for its position on the matter by the public and a pro-choice organisation.

The pharmacist followed the ethical guidelines by redirecting the customer to another pharmacy.

A spokesperson for Marie Stopes International said the Code should be "looked at again".

The Society had responded to over 30 media enquiries about EHC refusals over the last 12 months, said head of professional ethics Priya Sejpal.

"We hope that by educating the public about these provisions of the Code, they can achieve a better understanding of the rights of the pharmacist in these circumstances," she added. **JR**

News in brief

July Drug Tariff

The DH was expected to release details of next month's category M adjustments as C+D went to press. But it has not managed to agree with PSNC changes to fees and allowances in time for the July Drug Tariff, despite what the contract negotiator called its "best efforts". A DH negotiator said the amendments would "reflect market price changes without any further adjustments arising from the operation of the pharmacy contract".

Service pitch toolkit

The NPA is developing a toolkit to help pharmacists pitch services to PCTs. The practical workbook, expected to be ready by autumn, aims to help pharmacists to make commissioners aware of value-for-money aspects of their work. www.chemistanddruggist.co.uk

Non-referral criteria

The RPSGB Council has agreed criteria for minor complaints to be dealt with by the Society's inspectorate without referral to its investigating committee. www.chemistanddruggist.co.uk

NHS cut-carbon strategy

The government's carbon reduction strategy has been published for consultation. It highlights the need for all NHS organisations including pharmacists to reduce carbon emissions (see p37).

IT training on offer

Pharmacists are being offered IT training and support from NHS Connecting For Health as part of the Essential IT Skills Programme. www.chemistanddruggist.co.uk/news

Correction

The person pictured on p10 of last week's issue on the far right was Tracy Hudson, branch senior at Weldricks Pharmacy, and not pharmacist Wendy Atkinson. C+D apologises for the error.

NHS 60

NHS 60th survey

Go online to take part in the C+D survey about pharmacists' views on the NHS in its 60th birthday year. www.chemistanddruggist.co.uk

Dispensary TALK

Will you be dining at the RPSGB's new restaurant?



"I certainly won't be paying it a visit, not even for discounted coffee and biscuits. What a waste of money."
Raj Radia, Spring Pharmacy, London



"If I had the time I'd love to do it. But we run two pharmacies in the area so it's just getting the time."
Ferride Karson, Karsons Pharmacy, Kent

WEB VERDICT:

Yes: 20%
No: 80%

Armchair view: The thought of dining at the RPSGB appears not to be the flavour of the week.

This week: Have manufacturer-led supply deals made your job easier or harder? Cast your vote at **www.chemistanddruggist.co.uk/news**

Boots hits back in homeopathy sales row

Retailer accused by academic of not providing sufficient information to customers

Jennifer Richardson

Boots has defended its sale of homeopathic remedies after an alternative therapy expert accused it of breaching ethical guidelines.

Edzard Ernst, professor of complementary medicine at Exeter University, said the company did not provide customers with "necessary and relevant information" about some complementary medicines on its shelves, as required by the RPSGB Code of Ethics.

But a Boots spokesperson said its pharmacists did adhere to ethical guidance. She added: "Many people believe in the benefits of complementary medicines and we aim to offer the products our customers want."

Two hundred clinical trials had failed to show efficacy of homeopathic products, Professor Ernst said, and retailers should inform consumers they do not contain active ingredients.

"We have tested Boots on many occasions and in many places and we fail to see that they do this," he told C+D.

Boots denies claims pharmacists did not provide customers with "necessary" info when selling homeopathic products



However, the Boots spokesperson said: "Our pharmacists are trained healthcare professionals and are on hand to offer advice on the safe use of complementary medicines." She added that homeopathy is "recognised by the NHS and many health professionals".

Professor Ernst did not know if his concerns applied to other pharmacy companies, he admitted. "We have only targeted Boots simply because they are the largest and because they claim broadly that they can be trusted."

Should pharmacies sell homeopathic products?
jrichardson@cmpmedica.com

P&G: layout adds 10% to store sales

Pharmacy retail sales could grow by as much as 10 per cent if stores were made easier to shop in, Procter & Gamble (P&G) has said.

The company, whose brands include Gillette and Vicks, has launched its PharmacyCare Programme to help as many pharmacies as possible "improve shopability" and convert prescription footfall into retail sales.

P&G believes its long term growth in the sector will come from driving total category sales rather than trying to steal a bigger share of the market. It is working with marketing company Ceuta Healthcare to offer dedicated pharmacy shopping experts to help pharmacists improve their retail offering.

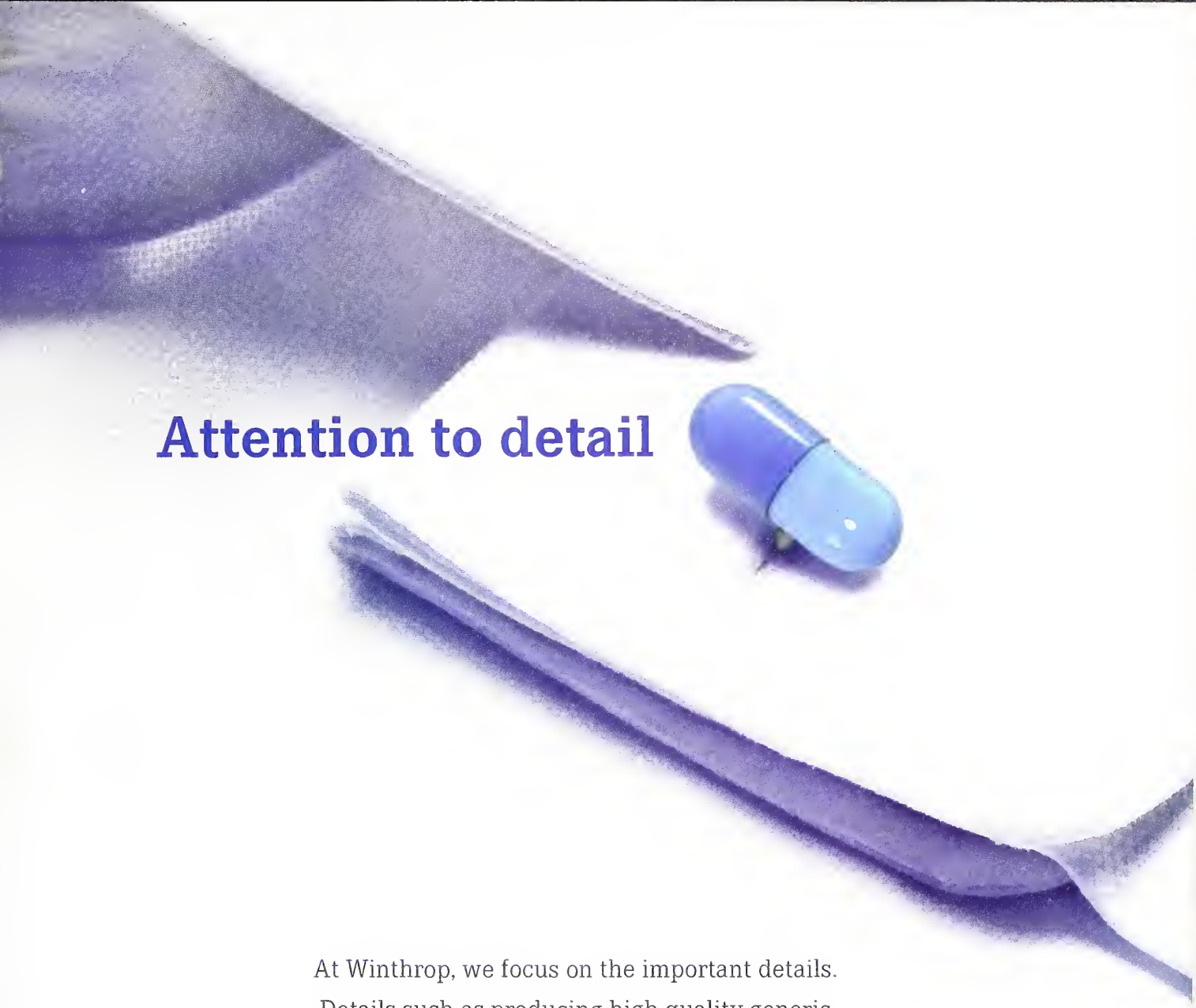
Tactics could include: redesigning shelf space; making signpost brands prominent; ensuring category space reflects sales; and helping to make stores as clean and light as possible.

The company currently offers re-merchandising of three key areas – oralcare, skincare and feminine hygiene – and is working with one lead store, analysing sales data and remerchandising the whole shop to inform the process and assess progress.

P&G is currently looking into how to roll the programme out on a larger scale.

The initiative was backed by industry leaders. NPA chief pharmacist Colette McCreedy said: "Professional retailing ensures that the whole of the pharmacy premises – not just the dispensary – projects a professional image." **ZS**

MUR ZONE
Not yet offering MURs?
See our guide to setting up an MUR service
Visit www.chemistanddruggist.co.uk/murzone or see p26



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www.chemistanddruggist.co.uk/murzone

News in brief

BPSA special meeting

The British Pharmaceutical Students' Association is holding a special general meeting to discuss its future in the context of current changes to the profession. It will be held at the London School of Pharmacy on July 19 from 10.30am.

Rx txt service

A communications tool has been launched that will enable pharmacists to contact their patients about medicines via telephone or SMS text. Pharmacy management systems supplier Cegedim Rx has created the Message Dynamics computerised service that dials to remind patients their prescription is due. www.cegedimrx.co.uk

Edwards quits NPA

Sarah Edwards has resigned from the NPA board of management following her decision to leave the pharmacy profession. An election is to be held in July to fill one of the two allocated places for Wales on the board.

MHRA challenges

The MHRA has published a summary of responses to its consultation on the medicines regulator's future priorities and challenges. The agency had already begun to implement suggestions through initiatives such as the Yellow Card publicity campaign, it said. www.mhra.gov.uk

Vioxx victory

Appeals courts in Texas and New Jersey have reversed two rulings against Merck & Co in liability cases concerning its withdrawn Cox-2 inhibitor Vioxx. The Texas court reversed a 2005 judgement that was in favour of a woman who claimed her husband's use of Vioxx (rofecoxib) caused his death. The New Jersey court overturned the punitive damage and consumer fraud awards of a 2006 verdict.

Heartfelt care

Pharmacies in Flintshire will be giving information to people suffering from a heart condition as part of this week's British Heart Foundation's Help a Heart Week. The participants will advise people who have been prescribed glyceryl trinitrate spray or tablets.

Sole island contractor may give up dispensing

Alleged lack of funding for rural pharmacies puts Isle of Mull business in jeopardy

Jennifer Richardson

The owner of the only pharmacy on a remote Scottish Island has threatened to relinquish his NHS contract due to insufficient funding.

Current pay for NHS services made them financially unviable for rural pharmacies, said James Heggie, of Tobermory Pharmacy on the Isle of Mull.

He said: "If the Scottish health department doesn't wake up and improve the remuneration to rural pharmacies, then this one will give up its NHS contract, concentrate on the profitable side of the healthcare business and ditch the dispensing."

He was reluctant to abandon a community service, but financial advisors had recommended it. "I would make more money by using the dispensary area for a gift shop," he added.

Ensuring adequate funding for rural pharmacies was "paramount", agreed Community Pharmacy Scotland spokesperson Alex MacKinnon. Both the contract negotiator and the Scottish Government said they were committed to this as part of their ongoing contract discussions.

Mr Heggie spoke out after he invited local MSP Jim Mather (SNP) to visit Tobermory Pharmacy, as part of C+D's Building Bridges campaign to raise the profession's political profile.

Mr Mather has yet to commit to a visit but said he had lodged Mr Heggie's concerns with the public health minister. "We are conscious of the pressures on pharmacies and on all small businesses in remote and island locations," he added.



The Isle of Mull faces the loss of its only NHS dispensary

Political divide on NI regulation

Ministers in Northern Ireland have clashed over whether the country should go on regulating its own pharmacists.

Health minister Michael McGimpsey stressed there was a "compelling" case for joining the UK-wide General Pharmaceutical Council (GPhC).

However, colleagues said signing up to the proposed London-based regulator was "ludicrous".

The comments came as ministers debated a motion backing the Pharmaceutical Society of Northern Ireland (PSNI) to retain independent regulatory and leadership roles in the province.

Mr McGimpsey warned that allowing PSNI to do both roles risked patient safety. He said: "The conflict of interest was recognised by other health professionals, such as doctors, nurses... it is important that a regulatory body sets standards for the profession in the interests of the public."

Mr McGimpsey said PSNI had "no substantive evidence" to support its claims that local regulation would be superior to a UK-wide alternative.

However, other ministers rallied behind PSNI.

Jim Shannon, MLA for Strangford, said: "Our system is already superior to that of GB – a fact that is universally acknowledged."

Alasdair McDonnell, MLA for Belfast South, added: "I am not sure any General Pharmaceutical Council could do better – in fact, it might do worse, because it would be 300-odd miles away."

Opponents claim independent regulation and representation are key for pharmacy to gel with wider health policy in the province, which is fully devolved. **MG**

Scotland to get increased drug rehab role

Pharmacists could play a greater role in substance misuse treatment under the Scottish Government's national drugs strategy, industry representatives have said.

Contract negotiator Community Pharmacy Scotland and principal pharmacist Alison Strath applauded the document's commitment to enhanced responsibility for rehabilitation, in addition to methadone dispensing and supervision.

Pharmacists' unique position of seeing a methadone patient every day, recognised in the strategy, enabled them to provide the "intense support" needed to gradually reduce dosages, Ms Strath said. "There's a great opportunity for pharmacists to take a wider role in the rehabilitation process."

NHS boards and pharmacies should ensure flexible access to services, including the use of new technologies, to enable recovering patients to return to work or education, the strategy recommended.

CPS planned to produce a full response to the strategy, which was published last week. **JR**

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*The recommended treatment course for *CHAMPIX* is 12 weeks and for the NRT patch (NiQuitin CQ Clear®) is 10 weeks. Continuous abstinence rate was CO-confirmed at weeks 9-12 for *CHAMPIX* and at weeks 8-11 for NRT

CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION – UK. (See Champix Summary of Product characteristics for full Prescribing Information). Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with *"Pfizer"* on one side and *"CHX 0.5"* on the other side and light blue, capsular-shaped, biconvex tablets debossed with *"Pfizer"* on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1 week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8 – End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment:* No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events:* Dosing may be reduced to 1 mg once daily. *Severe renal impairment:* 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease:* Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** *Effect of smoking cessation:* Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotharapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). Depressed mood may be a symptom of nicotine withdrawal. Depression, rarely including suicidal ideation and suicide attempt, has been reported in patients undergoing a smoking cessation attempt. These symptoms have also been reported while attempting to quit smoking with Champix. Clinicians should be aware of the possible emergence of significant depressive symptomatology in patients undergoing a smoking cessation attempt, and should advise patients accordingly. There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities. **Side-Effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side-effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal discomfort, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for less common, rare and very rare effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialysed in patients with end stage renal disease, however, there is no experience of dialysis following overdose. **Legal category:** POM. **Basic NHS cost:** Pack of 2 x 11 + 14 tablets £27.30, Pack of 56 1mg tablets (EU/1/06/360/003) £27.30, Pack of 28 1mg tablets Ca[illegible] (EU/1/06/360/00[illegible]) £27.30, Pack of 56 1mg tablets in PE Bottle (EU/1/06/360/00[illegible]) £54.60, Pack of 56 1mg tablets in PP Bottle (EU/1/06/360/002) £54.60, Pack of 56 1mg tablets Ca[illegible] (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, [illegible], Kent, CT13 9NJ, United Kingdom. **Further information** on request: Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey, KT20 7NS. Last approved: 07.2008

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Pfizer Date of preparation: February 2008 CHA432a

Under pressure to deliver MURs?

Are staff being victimised as employers chase MUR targets? C+D investigates

Bullying is not a problem confined to the school yard. One in four people are bullied at work, according to figures from anti-bullying charity the Andrea Adams Trust and it seems that pharmacists could be increasingly at risk.

The last few weeks have seen the sector's trade union publish guidance on the issue, and a team of researchers reporting "organisational pressure" as a tactic, possibly used by some employers to up MUR figures. Yet there appears to be a grey area where pressure to perform mutates into something more sinister.

It is a fact that multiples have led the way over independents in MUR delivery so far. A report published by a team at the University of Manchester showed pharmacy chains had performed three-quarters of MURs between April 2006 and March 2007. The chains have invested in consultation areas and the staff resources required to make the most of the service. With £27 available for every consultation, it's not surprising these operators want a return.

> "It's like being back in primary school and sent to the naughty chair"

But it is more by carrot than stick that the big multiples motivate their staff, according to Graham Webster, pharmacy operations director at Boots: "Our approach is to remove barriers preventing pharmacists from undertaking MURs. For example, we provide consultation rooms and training, ensure we have the right level of staffing and skill mix, and offer tips and hints on how to undertake MURs." When an employee is struggling, they are assigned a mentor to help, according to Mr Webster. However, the Boots director reflected: "There has been the odd occasion where perhaps clumsy management hasn't felt great for the pharmacist, but this is very much the exception."

Fellow high street giant Lloydspharmacy also says it adopts a softly softly approach to MURs. The company expects pharmacists to undertake the service, according to director of pharmacy Andy Murdock. But in return, employees are given the time, space and support to do so.

Similarly, Rowlands, which operates over 400 stores, said it looked to develop staff through training support. The company's national primary care liaison manager Liz Stafford told C+D: "Anecdotally I have heard of bullying with regard to MURs being mentioned by PCTs, however personally I have seen no evidence of this bullying."

This debate has been fuelled by the Pharmacists' Defence Association's claims that it has evidence of increasingly aggressive tactics used by some employers. The trade union said it had seen emails from unnamed organisations that threatened action for non-delivery of MUR targets. Some operators are "naming and shaming" underperformers, the PDA added.

These accounts are endorsed by some frontline staff. An employee from Wales told C+D: "If we were left to our own devices to do MURs, I would be very enthusiastic about doing them, but it's too much, it's like being back in primary school and sent to the naughty corner." Company emails are sent weekly with managers reporting to their seniors if a target was missed, the staff member revealed. "It's a form of corporate bullying. If I'd known when I did my degree it would be like this I wouldn't have done it."

Other pharmacists contacted by C+D echoed the feeling of a growing strain under MUR targets. Whether some employers are actually abusing professional guidelines is unclear. The RPSGB said MUR bullying was "complex and contentious". It could offer no immediate statistics on how widespread it is. An article written by the RPSGB on the subject is scheduled for publication in a future issue of C+D.

However, there are also many pharmacists who have successfully achieved MUR targets with the help of supporting structures put in place by their employers. But some in the profession will be relieved the government is reviewing MURs because it feels quantity has ruled over quality so far.

How are you supported in delivering MURs?
mgosney@cmpmedica.com

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Leaving Lambeth



The outgoing RPSGB president tells **Jennifer Richardson** about life at the Society in his first interview since standing down

The RPSGB has got its work cut out if it is to earn the support of members in forming a new professional leadership body, according to immediate past president Hemant Patel.

Having originally stood for Council because he thought it "out of touch with some of the thinking at a grassroots level", Mr Patel would like his three-term presidency to be remembered for making the Society more member-focused. He says: "I tried to introduce a degree of realism." Nonetheless, he believes there is "still quite a distance to travel" in this respect.

Mr Patel says: "The Society, despite the best efforts of Council members, has failed to establish daily relevance to practices of pharmacists... if they do not do so very quickly then the future might be precarious." And by "very quickly", Mr Patel means within the next four months, or at the very latest by December, in order for members to see "a minimum of 12 months of good quality support".

A step towards this engagement ideal would be to have Society staff spend one or two days a week in hospital, community and academic pharmacy settings, Mr Patel suggests, as he has done "on a regular basis" during his time on Council. Asked what the barriers have been to the implementation of this so far, he says: "Now that you've got a new chief executive, those possibilities are opening up." In the past, he adds: "The culture and practice has been to remain at Lambeth."

Indeed, this "slow pace of culture change" around Society staff's engagement with members' day-to-day practice has at times "seriously frustrated" Mr Patel during his presidency. "I know that it is not like pressing a button and getting an outcome," he admits, "but at the same time I'm sure things could be faster."

> "We have served two masters: government and the membership. The membership has always lost out"

While Mr Patel believes that "healthy tension" between Council members and Society staff is necessary, because their roles are different, Council frustration at the speed of policy implementation has sometimes created tension that is less than healthy, he reveals.

"When Council members come with energy, passion and ideas, often they are not translated into action. It creates frustration and I think once the Council or a committee agrees things it's the duty of staff to diligently and in a timely manner deliver what has been agreed, and that has not been the case on every occasion."

But Council must carry the can at least partially for the inactivity, he says. Those appointed need to be more demanding of the Society. "Council needs to get better at performance management," Mr Patel admits.

And despite some flaws, Mr Patel says that the Society's "highly qualified, well-paid" staff are, overall, doing a good job at a time of uncertainty surrounding the separation of the organisation's regulatory and professional leadership roles.

And he believes this fundamental change is "in some ways, the happiest day" for the Society, because it will free it up to develop that crucial member focus. Up until now, he says: "We have served two masters: government and the membership. The membership always lost out."

Even a herculean effort by the Society over the next crucial six months would not be enough to fully remove members' doubt, he says, but adds: "I hope they would be willing to take a small risk and support the new professional leadership body." Because Mr Patel believes the profession needs to take some responsibility for engaging with the Society themselves, in order to get the most out of it as it goes through the enforced split.

"Communication is a two-way thing," he says. "Be demanding and assertive... change is here whether we like it or not."

Hemant Patel on...

... being RPSGB president:

"It means a lot to me. I was always seeking a way to put something back into the country and the profession that has given me so much and I think being on Council, and especially as president, I was able to repay some of the debt."

... giving up the presidency:

"It was an emotional time because I care deeply about the Society and the profession. But I have to trust that the outcomes will be right."

... Society chief executive Jeremy Holmes:

"I look forward to working with Jeremy... I think his honeymoon period is over."

... the Clarke Inquiry:

"Community pharmacists could have done a bit more to vocalise their thoughts. The 'noisy brigade', the so-called Waterloo Group, probably had more of a say for the size of their representation."

... 2008's 40 per cent fee rise:

"What was done was done in the best interests of the membership. What was not done was adequate and timely communication with members explaining to them in detail why we needed to do what we needed to do... I genuinely believe it was the right decision and a brave one."

A communication by Procter & Gamble Pharmaceuticals

NEW



A fast route to symptom relief for moderate ulcerative colitis (UC) patients with new Asacol® (mesalazine) 800mg MR tablets dosed at 4.8g/day: what pharmacists need to know

Asacol (mesalazine) 800mg Modified Release (MR) tablets are now available on prescription. We asked Hannah McNally, Clinical Pharmacist, what pharmacists need to know about this new treatment option for patients with ulcerative colitis (UC) and Crohn's disease (CD):

Q. What type of patients will be prescribed Asacol 800mg MR tablets (dosed at 4.8g/day)?

A. Asacol 800mg dosed at 4.8g/day is indicated for patients suffering from moderate active UC

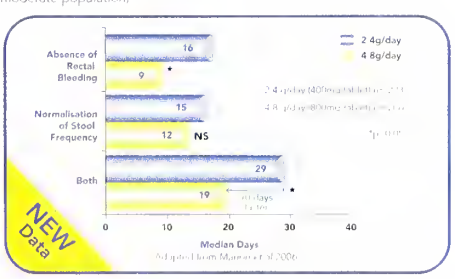
Asacol 800mg dosed at 2.4g/day is indicated for mild acute exacerbations of UC and up to 2.4g/day for the maintenance of remission therapy in both UC and Crohn's ileo-colitis patients.[1]

Q. What are the patient benefits of Asacol 800mg MR tablets dosed at 4.8g/day?

A. The ASCEND (Assessing the Safety & Clinical Efficacy of a New Dose of 5-ASA) I and II clinical trials evaluated overall treatment success as the primary endpoint. Additional results showed that Asacol 800mg MR tablets given at 4.8g/day provide symptom relief* 10 days faster (median time) than a mesalazine 400mg at 2.4g/day for moderate UC patients (figure 1).[2]

*Symptom relief is defined as both absence of blood in the stool and normalization of stool frequency

Figure 1
Median Time to Symptom Relief (ASCEND I and II pooled moderate population)



Time to symptom relief: the number of days from the first day of dosing to the first day of symptom relief.
Median time is the time for 50% of patients to experience symptomatic relief

The new dose of 4.8g/day also provides a significant improvement in quality of life at three weeks for moderate UC patients (as a mean change from baseline).[3]

Q. If I don't have any Asacol 800mg MR tablets in stock, can I give the patient Asacol 2x400mg MR tablets instead?

A. No. Interchangeability between Asacol 400mg MR tablets and the new Asacol 800mg MR tablets has not been established. According to MIMS, different mesalazines are not interchangeable and should be prescribed according to their mode and site of action with the brand name specified.[4]

In addition, for moderate acute exacerbations of UC only Asacol 800mg MR tablets are licensed for dosing up to 4.8g/day.[1] Asacol 400mg MR tablets are only licensed for doses at 2.4g/day for these patients.[5] Asacol 400mg MR tablets are not licensed at 4.8g/day.

Q. Will most moderate UC patients be switched from Asacol 400mg MR tablets to Asacol 800mg MR tablets (at 4.8g/day) or should I stock both doses?

A. Different mesalazines are not interchangeable[4] and it is advisable to stock both doses. Moderate UC patients will not be automatically swapped to Asacol 800mg MR tablets (dosed at 4.8g/day) as every patient is different and has different requirements from their treatment

Asacol 400mg MR tablets will still be available. UC or CD patients who are being successfully treated and are in remission should be maintained on this dose of Asacol 400mg MR tablets and not be switched to Asacol 800mg MR tablets. Asacol 800mg MR tablets may be prescribed for newly diagnosed patients and the higher dose of 4.8g/day may also be considered for those moderate UC patients suffering from flares in order to help achieve fast symptom relief.

Q. How should Asacol 800mg MR tablets be dosed?

A. Asacol 800mg MR tablets have the benefit of twice daily dosing,[1] thus avoiding the difficult lunchtime dose, which patients often forget to take. Divided dosing offers the convenience of twice daily dosing which is associated with better patient compliance[6] versus three times daily dosing.[7]

Q. Are there increased side effects with a higher dose?

A. There are no significant differences in the overall adverse event profile of Asacol 800mg MR tablets dosed at 4.8g/day at six weeks compared to mesalazine 400mg dosed at 2.4g/day.[8]

Q. How will Asacol 800mg MR tablets be packaged/dispensed?

A. Asacol 800mg MR tablets will be packaged in bottles, each bottle will contain a total of 180 tablets.

Q. What are the costs associated with prescribing Asacol 800mg MR tablets (4.8g/day) compared to Asacol 400mg MR tablets?

A. Asacol 800mg MR tablets cost the same as Asacol 400mg MR tablets on a gram per gram basis. Based on treatment at 2.4g/day for one month (30 days), both Asacol 800mg MR tablets and Asacol 400mg MR tablets cost £62.43. Asacol 800mg MR tablets dosed at 4.8g/day will cost £124.86.**

Asacol 800mg MR tablets are available in bottles of 180 and cost £124.86**.[4]

**Price at time of publication



Adverse events should be reported to Procter & Gamble Pharmaceuticals UK Ltd on 01784 474900. Information about adverse event reporting can be found at www.yellowcard.gov.uk

Date of preparation April 2008
AS7677/57007

P&G Pharmaceuticals

Asacol® 800mg MR Tablets Abbreviated Prescribing Information
Presentation: Asacol 800mg MR Tablets, PL 00364/0083, each modified release tablet contains 800mg mesalazine (5-aminosalicylic acid). Product is supplied in plastic (HDPE) bottles containing 180 tablets (£124.86). **Indications:** Ulcerative colitis: Treatment of mild to moderate acute exacerbations. For the maintenance of remission. Crohn's ileo-colitis: Maintenance of remission. **Dosage and administration:** Adults: Mild acute exacerbations: 3 tablets a day in divided doses. Moderate acute exacerbations: 6 tablets a day in divided doses. Maintenance of remission of ulcerative colitis and Crohn's ileo-colitis: Up to 3 tablets a day, in divided doses. **Elderly:** The normal adult dosage may be used unless renal function is impaired. **Children:** Not recommended. **Contra-indications:** A history of sensitivity to salicylates or renal sensitivity to sulfasalazine. Confirmed severe renal impairment (GFR less than 20 ml/min). Hypersensitivity to any of the ingredients. Severe hepatic impairment. Gastric or duodenal ulcer, haemorrhagic tendency. **Precautions:** Use in the elderly should be cautious and subject to patients having a normal renal function. Discontinue treatment immediately if acute symptoms of intolerance occur including vomiting, abdominal pain or rash. Patients with the rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine because of the presence of lactose monohydrate. Standard haematological indices (including the white cell count) should be monitored repeatedly in patients taking azathioprine, especially at the beginning of such combination therapy, whether or not mesalazine is prescribed. Asacol should be used in extreme caution in patients with confirmed mild to moderate renal impairment. Renal function should be monitored (with serum creatinine levels measured) prior to start of treatment, and periodically during treatment, taking into account individual history & risk factors. Mesalazine should be discontinued if renal function deteriorates. If dehydration develops, normal fluid & electrolyte balance should be restored as soon as possible. Serious blood dyscrasias (some with fatal outcome) have been very rarely reported with mesalazine. Haematological investigations including a complete blood count may be performed prior to therapy initiation and immediately if the patient develops unexplained bleeding, bruising, purpura, anaemia, fever or sore throat. Stop treatment if suspicion or evidence of blood dyscrasia. Lactulose or similar preparations which lower stool pH should not be concomitantly administered. Concurrent use of other known nephrotoxic agents, e.g. NSAIDs & azathioprine, may increase risk of renal reactions. Mesalazine should therefore be used with caution during pregnancy and lactation when the potential benefit outweighs the possible hazards in the opinion of the physician. If neonate develops suspected adverse reactions consideration should be given to discontinuation of breast-feeding or discontinuation of treatment of the mother. **Undesirable Effects:** Common: nausea, diarrhoea, abdominal pain, headache, vomiting, arthralgia/myalgia. Rare: reports of leucopenia, neutropenia, agranulocytosis, aplastic anaemia, thrombocytopenia, myocarditis & pericarditis, peripheral neuropathy, vertigo, bronchospasm, eosinophilic pneumonia, pancreatitis, alopecia, lupus erythematosus-like reactions and rash (inc. urticaria), bullous skin reactions, abnormalities of hepatic function and hepatitis, interstitial nephritis and nephrotic syndrome with oral mesalazine treatment, usually reversible on withdrawal. Renal failure has been reported. Suspect nephrotoxicity in patients developing renal dysfunction. Drug fever. Very rarely, mesalazine may be associated with exacerbation of the symptoms of colitis, Stevens Johnson syndrome & erythema multiforme, interstitial pneumonitis. **Legal category:** POM. **Marketing Authorisation Holder:** Procter & Gamble Pharmaceuticals UK Ltd, Egham, Surrey TW20 9NW. Asacol is a trademark. © 2007 Procter & Gamble Pharmaceuticals. Refer to Summary of Product Characteristics before prescribing. Date of preparation November 2007 AS7555

References: 1 Asacol 800mg tablets Summary of Product Characteristics 2 Marion JF *et al Gut* April 2006, Suppl 2, Vol **55** Abstract 140 3 Data on file, Procter & Gamble Pharmaceuticals 4 MIMS – Monthly Index of Medical Specialities (MIMS), UK, April 2008, page 212 5 Asacol 400mg tablets Summary of Product Characteristics 6 Carter *et al Gut* 2004, **53** (Suppl V) v1-v16 7 Greenberg RN *Clin Ther* 1984, **6**(5) 590-599 8 Hanauer SB *et al Gut* April 2006, Suppl 2, Vol **55** Abstract 106

Who's responsible for this mess?

Situation vacant: no experience necessary, long breaks an option. This new Responsible Pharmacist position sounds like a cushy number and I expect lots of people to apply.

Employees are bound to be paid more to be Responsible (rather than 'irresponsible') so they'll all want to be one. Proprietors with one shop and locums working in shops where they are the only pharmacist will have to be one. In fact, just about all pharmacists will be Responsible, making it a meaningless title.

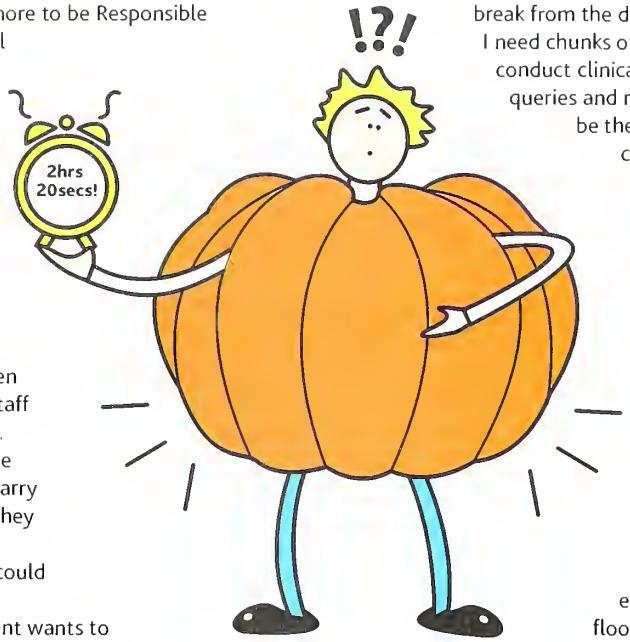


Illustration Jo Konopelko

But what are we going to do with all those two-hour breaks? I'd like to pop out to Starbucks for a coffee – in my dreams. A very few London-based pharmacists could even reap the benefits of their very own staff bistro at Lambeth (C+D, May 31, p7). Some pharmacists with nursing home business may even use this time to carry out their quarterly visits, as long as they don't get held up in traffic. Those on speaking terms with their local GPs could drop in on one of their meetings.

I suspect that, since the government wants to introduce these breaks despite many respondents voting against them, they have a hidden agenda around what we should do with this time. Maybe we are to help out GP receptionists or give talks at local schools. Whatever it is, it mustn't run late or be too far away from the pharmacy, or we won't be back in time and will risk turning into a pumpkin.

I think that, ultimately, everybody is missing the point. It's a break from the dispensary I need, not a break from the pharmacy. I need chunks of uninterrupted time to carry out MURs and conduct clinical services in the pharmacy. I can delegate most queries and routine dispensing to my staff but I still need to be there for final checks and unusual circumstances. I can visit nursing homes in my own time or get locum cover.

Leaving the premises is not cost effective, safe, or conducive to either good customer service or staff morale. The number of SOPs it would require to cover every eventuality in the absence of the pharmacist would require so much paper that the rainforests would never recover.

The government is undecided about the nature of the 'exceptional circumstances' that would allow remote supervision and so has left this up in the air. Surely the point is to define 'exceptional' rather than specific circumstances. I believe that exceptional circumstances should include one off, large scale emergencies such as pandemic flu or widespread flooding, but not staff shortages or pop concerts.

This whole consultation seems to be a bit of a mish mash and makes limited sense without considering supervision rules simultaneously. We're hoping for a minor miracle if we expect the end result to be remotely useful or practical.

Tender hooks



Fellow columnist John D'Arcy (C+D, May 17, p12) raises for the first time an issue that is causing considerable nervousness among Northern Ireland's contractors. For some months, the spectre of a tendering process for generics has been simmering beneath the surface and most of us are in blissful ignorance of what it means.

In May, confusion was lessened yet nervousness heightened following a meeting between the main generics houses and DHSSPS. It seems generic tendering may well be a given and could be implemented in 2009 or sooner.

So what is being proposed? While pharmacists and the industry are not exactly sure, it is suggested that tendering could be used to 'inform the drug tariff' and create a reduction in generic medicine prices with one exclusive supplier.

If that is the case, it might not be such a problem; the market will still exist and where there is a market there is always the possibility of doing business.

Yet I am concerned that a model might be in the pipeline that would cause pharmacists considerable problems. This model was used years ago for the supply of flu vaccines. It's actually rather a simple idea and, if I were a government minister, I would say it's quite brilliant. But as a contractor, all I can say is that this tendering model is Christmas and I am a turkey.

It could work like this: the five or six UK generic houses submit tenders and the winner gets an exclusive contract to supply generic medicines to the health service in Northern Ireland. Stock is then supplied to pharmacies via a nominated wholesaler but, and here is the big idea, at no cost. Prescriptions submitted for payment will only trigger a dispensing fee; there will be no drug cost reimbursement, as we didn't pay for the medicine in the first place.

It's a neat idea but, like all good ideas, it will have its downside. If – and this is unclear at this time – the model involves supplying stock to pharmacies at no charge, there will be a huge increase in pharmacy stock holding. Stock control will be irrelevant if medicines are free and, with no worry about medicines going out of date, I'm not going to risk being short of anything.

And I wonder how long it will be before this stock ends up in other UK pharmacies where reimbursements are still being paid. This, of course, is fraud, but the system being proposed will not easily track stock movement. It will prove a very wasteful scheme indeed.

The pharmaceutical programme at DHSSPS plans to save £54 million as part of the bigger overall saving of some £300m over three years. Fat is being taken from the system and I'm about to become an anorexic.

Terry Maguire is a community pharmacist in Northern Ireland

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Letters

Please email us with your letters to:

haveyoursay@cmpmedica.com

Or write to the Editor at:

C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

Letters may be edited for content and length

Control of entry: does it kill competition?

It seems that all independents care deeply about the future of independent community pharmacy, that is, until they come to sell up and then it's every man for himself.

I have been looking to buy my first pharmacy for about 18 months now. It's been tough going, many pharmacies are run down or the owners have simply run out of steam by the time they come to put the business up for sale. But, as a young, enthusiastic pharmacist I have been able to see the potential for regeneration, for engaging the local community and delivering high(er) quality healthcare.

We regularly hear that the independent sector is in decline, and that it must be because the number of independently owned pharmacies is going down. Wrong! The number of independents may be declining, but this is because when an independent comes to sell, they very often appear to be tempted by the higher valuations placed on them by some of the larger groups.

And thus, Mr Independent's highly valued pharmacy becomes yet another branch of [insert name here] pharmacy. Do patients care that their local pharmacy has been hoovered up by a chain? Why not ask patients at one of the pharmacies just up the road from me? Long waiting times, lost prescriptions, high levels of owings, low levels of staff satisfaction, and a generally poor service.

I work for an independent multiple and I have increased my prescription volume by over 50 per cent in three years, all because I offer a better service. We received top marks in our patient satisfaction survey and are generally held in high regard by the local community. But control of entry is simply stifling competition, and what is worse, it is patients who are the ones having to put up with the terrible levels of service in some pharmacies.

"But control of entry gives me security and allows me to plan ahead for my business," we hear. Does it? The surest way to protect your business is by competing on the one front where independents have the advantage: service.

I know every patient in my 9,000-item-a-month pharmacy by name. If they want to buy something, I already know that they are asthmatic or diabetic before they even speak. They know where to go if they have a question about their medicines because, when we dispensed it, I took the time personally to counsel each patient.

> "I should be able to open a pharmacy wherever I want to, and compete so that the person that provides the best service wins"

Nevertheless I am forced to watch from the sidelines as my hard work ends up in somebody else's bank account. No other business has a built-in firewall against competition, and pharmacy should be the same, I should be able to open a pharmacy wherever I want to, and compete so that the person that provides the best service wins – how can this possibly be a bad scenario? Patient wins, I win, bring it on. I succeed if I invest in improving my business – if I sit back and expect patients to put up with a second class service, I go out of business pretty quickly.

Instead, we are left with the worst of all possible worlds, the political compromise to control of entry.

Who benefits from all of this? Patients end up with a poor service, I have to push my nose up against the glass, and the few independents of the current generation get to push for higher and higher goodwill values based on the fact that they are the only pharmacy in the neighbourhood.

When somebody thinks they have found an opening for a new contract, the usual calamitous bun fight ensues: applicant says the service is necessary or desirable, and everybody else says it isn't, but then they proceed to put their own applications in for the same area! End result, PCTs have to judge who gets a contract out of the 16 identical applications. The losers appeal and we're back to square one.

Unless you have already got a pharmacy, it is very difficult it seems to get an application granted. I wonder how many applications were granted to people not already on the pharmaceutical list?

So, we have two choices: (1) the current system where the independent sector is headed for terminal decline as there are few new independents, and the existing ones are bought by larger concerns, or (2) a brave new independent sector which shrugs off the shackles of control of entry and begins to offer patients the best possible pharmaceutical services, where owner pharmacists care about their customers, because they are their livelihood.

You may think I am slightly, or even very, mad. Well, in truth, I might be, but independent pharmacy is so uniquely treasured by those that use it that I do not worry about us going the way of the fishmonger or the greengrocer.

For those independents too stressed out or busy to read the whole of this piece – selling your business is not just about the amount of money you can make. You are making a decision for better or for worse for the future of healthcare in your area, and as such, please consider those people you have seen every 28 days for the last 15 years. If you were them, who would you want to take over from you? A rotating door of temporary managers and locums, or a pharmacist who is committed to their wellbeing and to the local community and who is keen to look after their needs?

It is your decision, but based on my experiences over the last 18 months, it would appear a few extra quid in the bank is enough to assuage the consciences of most independents.

Name and address supplied

Should control of entry be scrapped?
haveyoursay@cmpmedica.com

MUR ZONE

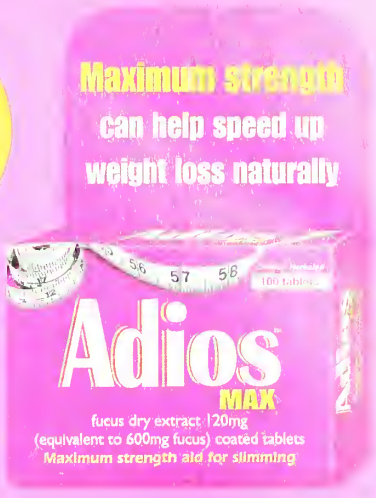
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C+D Clinical

Dementia

The fourth of our series of articles on mental health reviews dementia, in particular Alzheimer's disease

Key points

- Four types of dementia contribute to 90 per cent of the cases seen. Alzheimer's disease is the most common and affects memory as well as language, behaviour and performance of tasks.
- In Alzheimer's disease there is a progressive loss of acetylcholine nerve cells in the brain.
- Common treatment strategies attempt to reduce the decline of function by enhancing remaining acetylcholine.
- Cholinesterase inhibitors have numerous side effects and should not be used in some co-morbid conditions.
- Pharmacists can play a role in the management of patients with dementia by monitoring on an informal basis to ensure treatment is appropriate, and to avoid interactions.

Stuart Gill-Banham MRPharmS

Reflect

What is the rationale behind the drugs used in Alzheimer's disease? What are their potential side effects and what are the main drug interactions? What is Lewy body dementia?

Plan

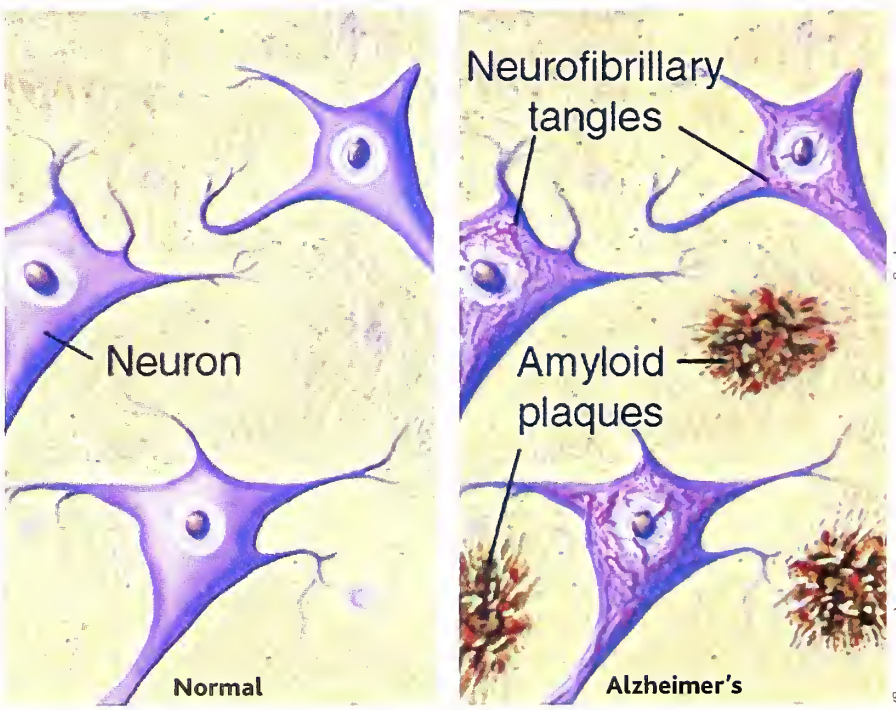
This article describes the four most common types of dementia, particularly Alzheimer's disease and the drugs used in its management.

CPD This article can help in the following CPD competencies: **G1a, G1c, G1e, G1f, C1a, C1c, C3b.** See http://tinyurl.com/68ox7b

One of the greatest fears that individuals may have of increasing age is the likelihood of dementia. Remembering everyday details seems to become more difficult as we get older, but this is not quite the same as dementia, which is a term used to describe gradual long-term disruption of a range of key brain functions, including memory. It also affects language, emotion, personality and visuospatial skills.

Memory loss is key to the common perception of dementia, but it is characteristically different from the routinely encountered 'senior moments'. To lose your keys or forget someone's name are common examples of age-related memory loss. Unfortunately in dementia, the individual is more likely to forget what the keys are for or who the person is. This is particularly disturbing when it is somebody close, such as a spouse or relative.

It is the loss of the individual personality, the essence of being, that makes us people and makes dementia especially upsetting for the relatives caring for that individual.



Greater numbers of defective or dying nerve cells are found in the brains of Alzheimer's disease sufferers

Reprinted with the permission of Alzheimer's Disease Research, a program of the American Health Assistance Foundation (www.ahaf.org)

Types of dementia

Four different dementia illnesses account for 90 per cent of cases encountered.

Alzheimer's disease	50 per cent
Lewy body dementia	15 per cent
Frontal temporal dementia	15 per cent
Vascular dementia	10 per cent

Alzheimer's disease is characterised by difficulty in learning and retaining new information. Over time there are also difficulties with calculation, visuospatial skills, performance of tasks and language. **Lewy body dementia** is characterised by the presence in the brain of Lewy bodies – small, spherical, protein deposits. The condition has similar symptoms to those for Alzheimer's, in respect of cognitive

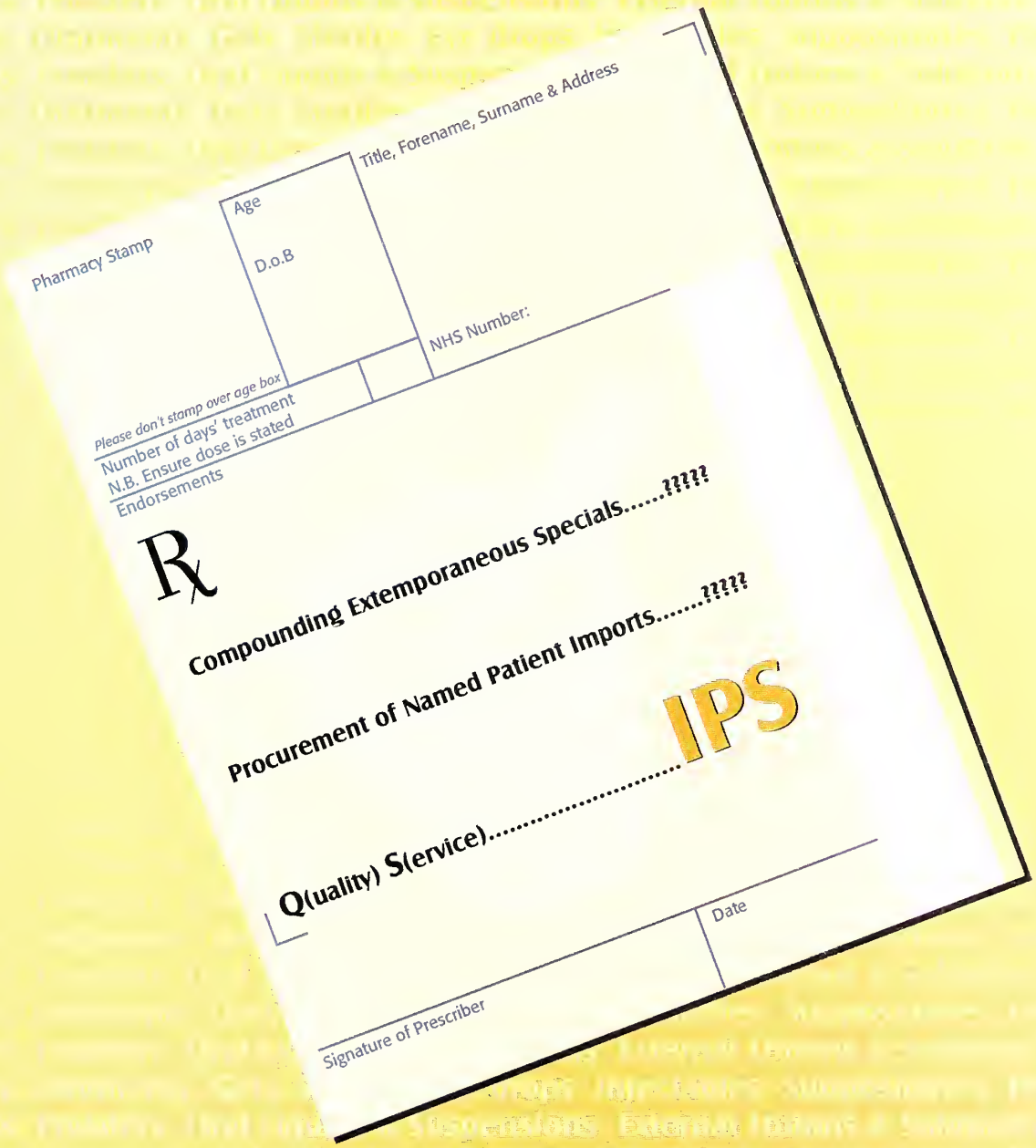
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This course (module 1441), in association with multiple choice questions being published in C+D July 5, provides one hour's continuing education

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dysfunction. However, visual hallucinations and features of Parkinson's disease can also occur. Lewy bodies are found in patients with Parkinson's disease, and PD patients can develop a form of dementia similar to Lewy body dementia. This suggests a possible link between the two conditions.

Frontotemporal dementia is characterised by earlier onset of behavioural changes, while visuospatial skills are still intact. An individual may exhibit poor hygiene, lack of social tact and possible sexual disinhibition.

Vascular dementia results from interruption of blood supply to the brain, either as a result of haemorrhagic or ischaemic events. Along with symptoms of cognitive decline, there may be symptoms suggestive of a stroke. Sometimes patients with vascular dementia will have periods of stability followed by sudden declines in cognitive function, correlating to another cerebral vascular event occurring.

The remaining 10 per cent of dementia cases are made up of a range of diverse disorders such as Creutzfeld-Jakob disease, Aids-related dementia and Huntington's disease. The rest of this article will focus upon Alzheimer's disease as this is the most prevalent form of dementia.

Table 1: The development of symptoms in Alzheimer's disease

Illness stage	Clinical presentation
Early: first three years	Impairment of recent memory, forgetting names, losing direction when out, language difficulties, depression, impaired activities of daily living (ADL)
Mid: second to 10th year	Amnesia, aphasia, inability to problem solve or perform calculations, personality changes, behavioural changes, inability to perform ADL
Late: eighth to 12th year	Short and long-term memory loss, mutism or nonsense speech, rigid posture, double incontinence, complete dependence on others

Table 2: Cholinesterase inhibitors and their potential side effects

Cholinesterase inhibitor	Potential side effects	Conditions that may be exacerbated
Donepezil Galantamine Rivastigmine	Nausea/vomiting, dizziness, insomnia, diarrhoea, sweating	Peptic ulcer disease, asthma, COPD, bradycardia

Alzheimer's disease

In Alzheimer's disease there is general shrinkage (atrophy) of the brain, especially in the frontal, parietal and temporal lobes in areas responsible for functions such as memory, personality, speech and language. Overall brain volume may be reduced by as much as 15 per cent, with a corresponding reduction of central neurones and reduced neurotransmitter levels, particularly acetylcholine.

A key finding on post-mortem is widespread neurofibrillary tangles and neuritic (senile) plaques – the remains of defective or dying nerve cells. They are associated with normal ageing but in Alzheimer's disease greater numbers are found and their occurrence corresponds with disease duration, severity and presence of greatest nerve cell loss.

Neurotransmitter hypothesis

Cholinergic neurones, which utilise acetylcholine as the key neurotransmitter, are crucial to cognitive functions including memory. Depletion of cholinergic nerve cells and corresponding decline in neurotransmitter level correlates with the loss of memory and cognitive decline.

By the time mild symptoms of Alzheimer's disease are detectable, significant loss of acetylcholine will already have occurred. Often the level of acetycholine will have halved before a diagnosis is made or treatment is commenced, but in moderate to severe disease the levels may have reduced by anything between 40 and 90 per cent. This is important to remember when considering the current treatment strategies for managing Alzheimer's disease, as most rely on enhancement of existing acetycholine for their therapeutic effect.

Progression and staging

Table 1 (above) outlines how symptoms develop in Alzheimer's disease as the illness progresses with continued loss of nerve cell function.

The Mini Mental State Examination (MMSE) is a brief, 30 point questionnaire for assessing cognitive function. Different questions and tasks are used to assess a range of functions including orientation, recall, spatial perception and simple arithmetic. Possible scores range from 0 to 30 and, although some debate exists, a score less than 24 is suggestive of mild cognitive decline. Scores between 10 and 20 suggest moderately severe cognitive decline, while a score of less than 10 indicates severe decline. Although the MMSE is not perfect, and is influenced by premorbid educational level, it is nevertheless widely used in both psychiatry and general medicine.

After establishing the presence of impaired memory and cognition, Alzheimer's disease is usually diagnosed only after other causes have been excluded, eg general medical conditions or psychiatric disorders that might reduce cognitive function.

Treatment strategies

As yet there are no treatments for Alzheimer's disease or any other forms of dementia. Nothing has been discovered that can reverse or even halt the decline of brain function. Current drug strategies slow disease progression and may bring about some degree of symptomatic improvement in the initial stages of therapy.

Unfortunately the disease will progress, and ultimately the individual will continue to experience decline in memory and cognitive function.

Cholinesterase inhibitors (ChEIs)

This group of drugs forms the mainstay of symptom management in Alzheimer's disease. In clinical trials they have been found to produce significant, although clinically modest, effects on cognitive function. Often the trials have been criticised because of their short duration and other methodological flaws.

The therapeutic effect of this class of drugs is thought to result from inhibition of the enzyme cholinesterase, which is responsible for cleavage of acetylcholine in the nerve synapse – inhibiting this enzyme is believed to enhance remaining neurotransmitter levels.

Table 2 (above) details specific examples of ChEIs and some of their side effects, which are due to increased acetylcholine levels outside the CNS.

Although the three ChEIs are fairly similar, subtle differences do exist in terms of individual tolerability and prescribing. For example, donepezil and galantamine are both hepatically metabolised and can form the substrate for drug interactions mediated via hepatic enzymes (specifically CYP2D6 or CYP3A4). Rivastigmine is not hepatically metabolised so does not have the same interaction potential.

The ChEIs are licensed only for the treatment of Alzheimer's disease. There is growing support for their use in other dementia types, particularly vascular and Lewy body dementias. Such off-label use is difficult to justify within the NHS when Nice strictly controls the use of these agents for their licensed indication.

Memantine

Memantine has a different mechanism of action from the ChEIs. It reduces the cascade of nerve cell death that is thought to contribute to dementia disease progression. It is licensed for use in severe Alzheimer's disease, where the effect of enhancing acetylcholine levels is minimal following a large decline in neurotransmitter level. The most common adverse effects of memantine are hallucinations, confusion, dizziness, headache or drowsiness.

What does Nice say?

Despite considerable controversy and objections from professional groups, patient groups and pharmaceutical companies, Nice has maintained its recommendations on the pharmacological interventions for the cognitive symptoms of Alzheimer's disease.

Donepezil, galantamine and rivastigmine can be used in disease of moderate severity only (MMSE score 10-20), providing they are initiated by specialists in the care of dementia and that patients are reviewed at least six-monthly.

Memantine can only be initiated for moderate to severe dementia if this is part of a well designed clinical study.

These prescribing guidelines do not reflect concern over the safety of these drugs, rather they are an attempt to ensure good economic return on NHS investment.

Table 3: Drugs likely to alter hepatic enzyme activity

Notable enzyme inhibitors	Notable enzyme inducers
Fluoxetine	Rifampicin
Paroxetine	Rifabutin
Clarithromycin	Carbamazepine
Erythromycin	Oxcarbazepine
Fluconazole	Phenytoin
Itraconazole	
Ketoconazole	
Grapefruit juice	
Diltiazem	
Cimetidine	

This table is not a complete list. It illustrates some of the commonly encountered enzyme inhibitors or inducers of CYP2D6 or CYP3A4

Drug interactions

As previously mentioned, drugs that inhibit or induce the activity of hepatic enzymes (CYP2D6 or CYP3A4) can either increase the activity of ChEIs, which will lead to greater side effects, or reduce their activity, possibly resulting in a loss of effect. Rivastigmine is not hepatically metabolised so will not be affected by these interactions. Table 3 (left) gives examples of drugs likely to alter hepatic enzyme activity.

There is a potential for all ChEIs to interact with any medicine that inhibits cholinergic activity. Such medicines may be specific antimuscarinics, eg procyclidine or oxybutynin. The use of anticholinergic medicines in a patient with cognitive dysfunction is questionable, regardless of whether they are prescribed a ChEI or not. Some anticholinergic medicines will affect central acetycholine function and can lead to reduced cognition even in otherwise healthy adult patients.

Stuart Gill-Banham MRPharmS, MCMHP, is a clinical lecturer at Medway School of Pharmacy. From 2003 to 2007 he was registrar of the College of Mental Health Pharmacists.

Further reading
Nice Clinical Guideline 42 – Supporting People with Dementia and their Carers in Health and Social Care

• MUR tips are online at www.chemistanddruggist.co.uk/murzone

Your Continuing Professional Development CPD

Aim

• Read the BNF section on drugs for dementia, noting in particular the starting doses and how they should be increased.
• Find out more about the difference between memantine and the anticholinesterases, and list the drugs with which memantine might interact.
• Read the Nice quick reference guide (September 2007) on drugs used in Alzheimer's disease (www.nice.org.uk/cg42), which gives recommendations on their NHS availability.
• Check your PMRs for people taking drugs for dementia. Are any other drugs being prescribed at the same time? If so, can you simplify the regimens to make it easier for patients or their carers to remember?
• Check if any of these patients are also taking prescription medicines with anticholinergic side effects, such as antidepressants or antipsychotics. What should you do about this?
• Some OTC medicines have anticholinergic side effects. Make a note of those that should be used with caution or avoided in Alzheimer's disease. Add this to your relevant patient records.
• Look at the Alzheimer's Society website (www.alzheimers.org.uk) for factsheets that might be useful to patients or their carers. Read about the different types of dementia, its diagnosis and progression, risk factors and tips for reducing risks. Make a note of the Alzheimer's Society helpline and your local branch for possible future reference.

Example

• Could you answer queries on drugs used in Alzheimer's disease, how they act and their side effects, as well as their NHS availability?

CPD Online searchable CPD archive

Do you keep the Update articles for reference? Are there any missing from your collection? Why not check C+D's online archive at: www.chemistanddruggist.co.uk/update

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Clinical Alerts

New Products

Circadin 2mg prolonged-release tablets (melatonin) For short-term treatment of primary insomnia in adults aged 55 years and above. Lundbeck Ltd, tel: 01908 638972; ukmedicalinformation@lundbeck.com

SPC Changes

Avodart 0.5mg soft capsules (dutasteride) Extensive changes including information on the importance of risk assessment. GlaxoSmithKline UK, tel: 0800 221 441; customercontactuk@gsk.com

http://emc.medicines.org.uk

More alerts at www.chemistanddruggist.co.uk/clinical

Nice guidelines cause concern

Nice guidelines on statin treatment and type 2 diabetes published this week have received mixed reviews.

On statin treatment, the British Heart Foundation welcomed Nice's approach to identifying risk but said that relying on patients to attend GP surgeries for assessment will fail many socially deprived and ethnically diverse patients.

The campaign group Diabetes UK applauded Nice's recommendations on education for type 2 diabetes patients, but criticised the decision not to adopt the tight blood pressure control targets outlined in the earlier Joint British Societies 2 and Chronic Kidney Disease guidelines, and also the inclusion of advice not to pursue intensive management aimed at bringing blood glucose below 6.5 per cent.

Nice has pledged to publish a rapid update of treatments including DPP-4 inhibitors during 2009. A member of this class, sitagliptin, was recently accepted for use in Scotland by the SMC.

www.nice.org
www.bhf.org.uk
www.diabetes.org.uk

Sign up for C+D's clinical newsletter at www.chemistanddruggist.co.uk/register

Gout latest results

Oral prednisolone and naproxen have been shown to be equally effective in treating gout over four days. The trial results appeared in The Lancet, May 31.
www.thelancet.com

Opioid constipation

A study of 133 patients with opioid-induced constipation has shown rapid laxation in patients treated with subcutaneous methylnaltrexone. The injections did not appear to affect the patient's analgesia or induce opioid withdrawal.
http://tinyurl.com/3w6mqb

For more clinical news stories go to: www.chemistanddruggist.co.uk/clinical

A Practical Approach — Worsening asthma



David Farram

David Spencer, pharmacist at Update Pharmacy, is in the front shop when John Harding comes in.

"Hello, Mr Spencer," he says. "Did you have a good holiday?"

"Fine thanks," replies David. "But that was over a month ago, how did you know about it?"

"I came in with a prescription and there was a stand-in pharmacist here. That's why I'm back now – I don't think that he gave me the right asthma inhalers. Have a look."

Mr Harding holds out a salbutamol inhaler and a beclometasone 200mcg inhaler, "They're the right names but they don't seem to be working properly. I've had to use them more often than I used to but I'm still getting wheezy, while I was fine on the ones you gave me."

David looks at the inhalers. "Yes," he says, "these are from a different supplier. We switched a couple of months back. But they should be identical to the ones we used to give you and just as effective. Was it just the repeat of the inhalers you came in for when I was away?"

"Actually no. I'd been getting chest pains when I did anything very strenuous. My doctor said I had angina and prescribed a whole load of medicines."

"OK. Just hold on while I check what they were," David replies.

Mr Harding's PMR shows that his last prescription was for: atenolol 100mg od, pravastatin 40mg on, aspirin 75mg od, a brand of modified release isosorbide mononitrate (ismn) 60mg m & n, a glyceryl trinitrate spray prn, plus the asthma inhalers.

"Oh, and by the way," says Mr Harding when David returns. "I don't think that angina spray is much good either, I've been using it more and more in the last couple of weeks."

Questions

1. What is the more likely cause of the apparent worsening of Mr Harding's asthma than the switch in generic brand of inhalers, and what could be done about it?
2. What might be the cause of the apparent ineffectiveness of the GTN spray, and what could be done about it?

This article can help in the following CPD competencies: **G1a, G1c, G1e, C1a, C3e.** See http://tinyurl.com/68ox7b

Answers

1. Atenolol is a cardioselective (beta$_1$) beta-blocker. Although it may have less effect on lung function than non-selective beta-blockers, it can still cause bronchospasm and should be avoided in patients with asthma unless there are compelling reasons for its use. Diltiazem, a calcium channel blocker, might be a suitable alternative as an anti-angina treatment. Atenolol should be withdrawn gradually, over seven to 14 days, to avoid exacerbation of angina.
2. Nitrate tolerance may have developed to long-acting ismn, requiring more frequent use of the GTN spray to treat angina attacks. Once the patient has been stabilised on diltiazem (or other replacement for atenolol), twice daily ismn should be withdrawn gradually and replaced with a once daily dose of 60 to 120mg in the morning to allow a nitrate-free period.

C+D's A Practical Approach is supported by APOTEX UK LTD

MUR ZONE
Get MUR tips ...
For your consultation, browse by condition or drug
Visit www.chemistanddruggist.co.uk/murzone or see p26

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www.chemistanddruggist.co.uk/murzone

The C+D MUR Zone

C+D's MUR Zone is an innovative collection of tools designed to help you turn your MUR theory into practice. From today you will find it online at www.chemistanddruggist.co.uk/murzone

The C+D MUR Zone's killer feature is a collection of more than 90 short guides listing key questions you can ask patients. They're an aide-memoire and a way to really get the MUR conversation started.

There are MUR tips on a wide range of both diseases and drug classes and more will be added over the coming months – links from the MUR home page provide working pharmacists with rapid access to indexes of both.

Why not add our MUR zone to your collection of bookmarked web addresses right now?



BEGINNERS START HERE

MUR Guides

These are the nursery slopes for those of you who are not yet doing regular MURs.

These links explain the theory and guide you through the process of doing MURs.

GET FULLY TRAINED HERE

MUR Training

Sign up to C+D's training which covers both MURs and medicines management.

WIDEN YOUR RANGE OF MURS HERE

MUR Tips

MUR tips listed by the patients' disease or drug class will give a flying start to your next MUR – particularly if it's your first in a new area.

The tips currently include 20 conditions and more than 70 drug classes, and more are scheduled to be added over the coming weeks and months.

To make sure you're informed about new MUR guides, sign up for our regular clinical newsletter at www.chemistanddruggist.co.uk/register

ADD YOUR COMMENTS HERE

Comments

C+D's MUR Zone is a living community – we want to encourage users to comment and add to the content on a regular basis.

Clinical editors at C+D will then review the comments regularly, and make sure that your most valuable additional points are then included in the MUR guides.

What pharmacists on C+D's clinical panel have said about the MUR Zone

"I'm very impressed. The MUR Zone allows pharmacists to access information for themselves, and provides links to Prodigy information for the patient"

"It's a good idea to list tips by disease, as there are definitely some conditions where I shy away from doing MURs at the moment!"

"I have looked at your MUR Zone and I'm really impressed. I think it's a really good idea to have all the tips listed. Please make sure you advertise it heavily in the magazine, because pharmacists will find it useful"

New Otex Express from the No.1 ear wax brand*



Otex Express EAR DROPS

Dual action
For rapid removal of hardened ear wax
Reduces need for syringing
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- Otex brand on TV throughout 2008
- Expect high demand

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OTEX Trademark and Product Registration held by Diomed Developments Ltd., Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd., 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **ndications:** Otex Express Ear Drops: An aid in the removal of hardened ear wax. **Directions:** For adults, children and the elderly: Instill up to 5 drops into the ear. Retain drops in ear for several minutes and then wipe away any surplus. Repeat once or twice daily for at least 3 to 4 days, or as required. **Contraindications:** Do not use if the eardrum is known or suspected to be damaged. n cases of dizziness, or if there is, or has been, any other ear disorder. Do not use after ill-advised attempts to dislodge wax using fingernails, cotton buds or similar implements, or within 2 to 3 days of syringing. Do not use where there is a history of ear problems, unless under close medical supervision. Do not use if sensitive to any of the ingredients. Do not use at the same time as anything else in the ear. **Precautions:** Keep away from the eyes. For external use only. Replace cap after use, and return bottle to carton. **Side-effects:** Due to the release of oxygen, patients may experience a mild, temporary effervescence in the ear. Stop usage if irritation or pain occurs. Instillation of ear drops can aggravate the painful symptoms of excessive ear wax, including some loss of hearing, dizziness and tinnitus. Very rarely, unpleasant taste has been reported. If patients encounter any of these problems, or if their symptoms persist or worsen, they should discontinue treatment and consult a doctor. **Packs:** Otex Express Ear Drops 10ml, RSP £4.95 (£4.21 exc. VAT). **Revision Date:** December 2007. *Source: IMS Dec MAT 2007.

Want to boost OTC sales? Get C+D's products e-newsletter at:
www.chemistanddruggist.co.uk/register



Back in blue

Zantac 75 begins a national television campaign this week, aiming to drive trial and boost penetration over the summer, reports manufacturer GSK. The heartburn and indigestion remedy will be on air for five weeks in the £615,000 campaign.

The familiar blue man from the product's packaging is brought to life in the ads to highlight its 'up to 12 hour' relief claim and show how Zantac 75 works.

Women aged 45 plus are the key target for the ads, which are running on terrestrial and satellite channels. Reinforcing the TV activity, PoS materials and promotions are aiming to educate consumers and drive sales.

Product info:
Ceuta Healthcare
Tel: 01202 780558

Pain gets the cold shoulder

A £900,000 multimedia campaign is supporting the WellPatch Deep Freeze Cold Patch this summer, says manufacturer Mentholatum. Spanning television, online and retail activity, the initiative is running until September.

TV advertising is scheduled around sporting events including Euro 2008, the Tour de France, boxing and rugby. The ad begins this week on terrestrial and satellite channels and is a repeat of last year's, with a new soundtrack.

Online activity is planned for www.physioroom.com and the sites of health, fitness and sporting magazines. The product will be further promoted on Tesco Clubcard and Boots Advantage card statements this month.



Product info:
Laser Healthcare
Tel: 01202 780558

National Smile Month
18 MAY - 17 JUNE 2008
British Dental Health Foundation

Prize time

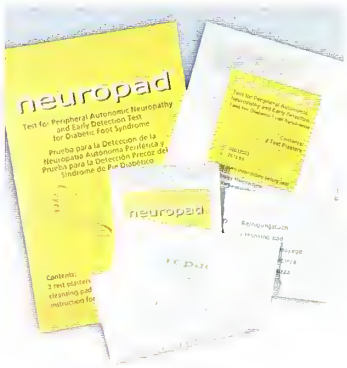
The two lucky winners of the Oral-B competition (C+D, May 24) are Thomas Cox of Murrays Pharmacy in Bewdley and Carol Doherty of Village Pharmacy in St Helier. Congratulations! Your Oral-B ProfessionalCare 8900 will be sent out by Oral-B's PR agency.

Products in brief

Be callous to calluses

ClearZal Callus crème has been relaunched. The registered medical device contains salicylic acid, trichloroacetic acid and urea, and claims to be clinically proven to remove calluses. The whole range is now available in Northern Ireland from Prima Brands.
Zeon Healthcare
Tel: 01869 238361

Finding foot faults – fast!



Neuropad is a new diagnostic test for the early symptoms of diabetic foot syndrome from Ark Therapeutics. It is said to be easy to use and cost effective. Patients can buy the test to use at home or pharmacists could offer testing as a consultation room service.

The Neuropad is presented as an adhesive dressing and applied to the plantar surface of the foot to assess the function of sweat glands. Moisture status is registered via a colour change and is visible within 10 minutes.

Sensitivity of the Neuropad is similar to nerve conduction studies, considered the gold standard for diagnosis of diabetic neuropathy, says Ark.

Price and Pip code:
£69.90/10, 337-0665
UDG; tel: 01773 510123
csg.udg@udg.co.uk

Keep suncare handy

Sachets of Uvistat SPF30 sun lotion are newly available. Containing 7.5ml, the sachets are designed for a single application to the head, face, neck and arms of a typical adult.



Manufacturer LPC Medical hopes the sachets will appeal to consumers looking for convenience when enjoying outdoor activities and not wanting to carry a whole bottle of sunscreen.

Uvistat is fragrance-free and suitable for sensitive skin. It offers five star UVA protection.

Prices and pip codes: £6.99/10, 335-6920; 79p/1, 335-6904
LPC Medical
Tel: 01582 560393

Needle and dread

Emla, the P-licensed local anaesthetic cream, is receiving a promotional boost from manufacturer AstraZeneca to raise awareness of its uses before injections and availability. Websites for consumers and professionals have been created, with links between the two.

The consumer version is at www.ihateneedles.co.uk and has been designed for building a community where visitors can share their needle fears and using Emla. Videos can be uploaded and links made with sites such as Facebook and MySpace.

Containing prilocaine and lidocaine, the cream can be used to numb the skin prior to injections from the age of one. Among suggested uses are travel vaccinations, blood donation, blood tests and routine immunisations, minor cosmetic procedures and tattoos.

A pre-injection numbing kit is available free to pharmacies, for sale alongside the 5g cream for a suggested selling price of around £5.50. PoS materials are available.

Product info:
AstraZeneca; tel: 0800 0304696
www.emla.co.uk

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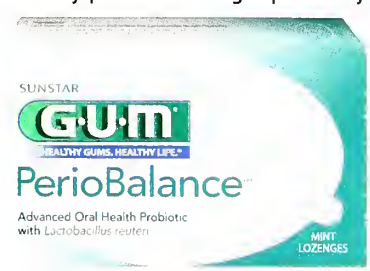
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200 MILLION PROBIOTICS ALL IN ONE LOZENGE.

FOR A HEALTHY MOUTH.

The only probiotic lozenge specifically formulated for oral health. Changes in oral microflora balance can lead to periodontal disease and caries.[1] **GUM PerioBalance** is an advanced oral health probiotic that contains ***Lactobacillus reuteri Prodentis*** - the only probiotic currently known to produce a beneficial, natural anti-microbial agent that helps prevent the growth of harmful bacteria without affecting the other 'friendly' health promoting micro-organisms of the mouth. **GUM PerioBalance** is formulated to help maintain a balanced natural micro flora for oral health, decrease bacterial plaque build up, significantly reduce gum bleeding and inflammation, and fight the harmful bacteria in the mouth that are responsible for gum and tooth decay. Used together with tooth brushing and flossing, **GUM PerioBalance** is an innovation intended to enhance the natural defences of the mouth for improved oral health. Suitable for adults and children of all ages, it is available as a dissolvable lozenge.



1. Çaglar E et al. Oral Disease 2005; 11: 131-137

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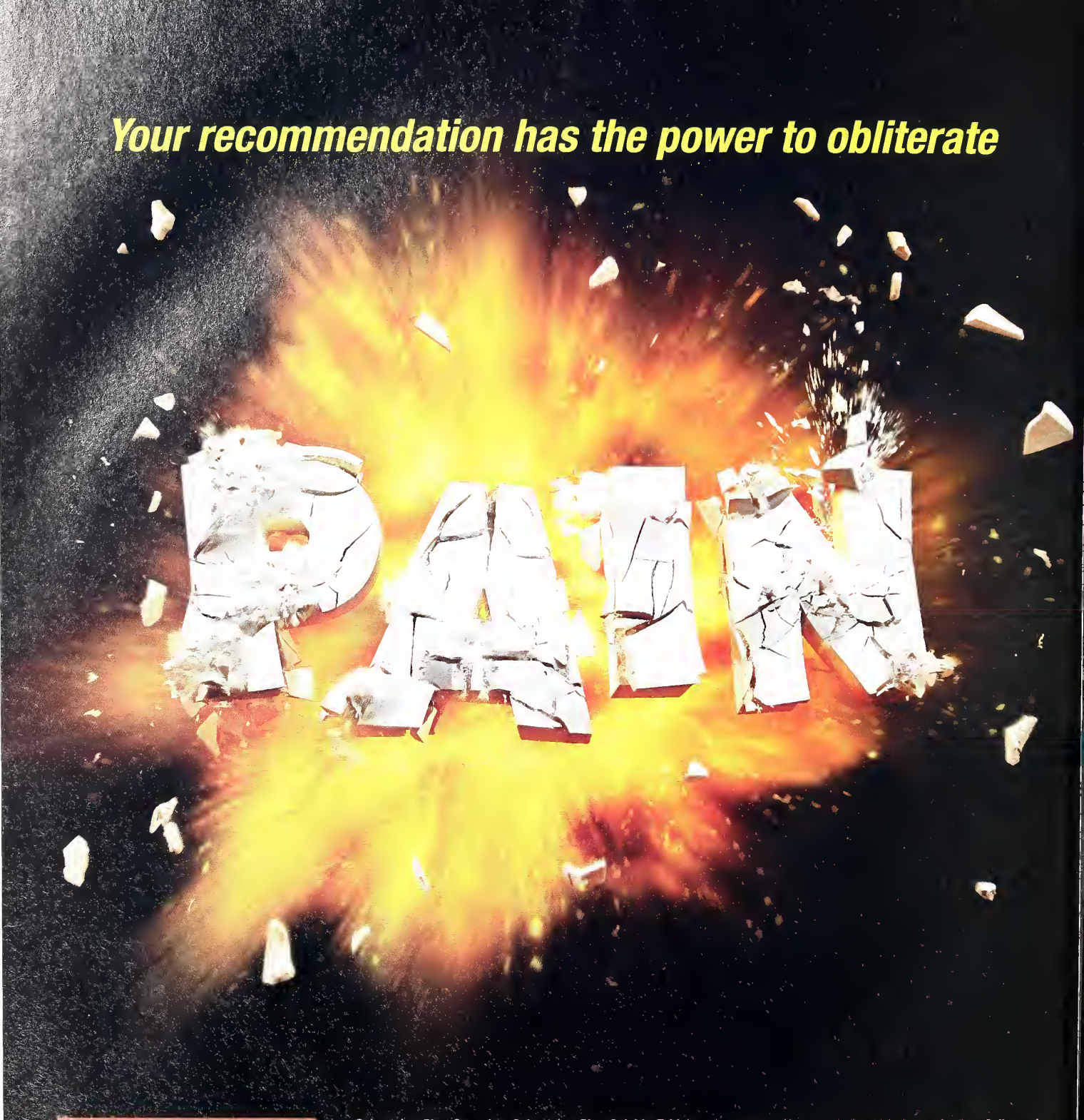
www.sunstargum.co.uk

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Your recommendation has the power to obliterate





Paracetamol + Codeine + Caffeine

Solpadeine Plus Capsules, Solpadeine Plus Soluble Tablets, Solpadeine Plus Tablets. Product Information. Presentation: Each tablet, soluble tablet or capsule contains Paracetamol 500 mg, Codeine Phosphate Hemihydrate 8 mg and Caffeine 30 mg. **Uses:** Migraine, headache, backache, rheumatic pain, period pains, toothache, neuralgia, sore throat and feverishness, symptoms of colds and influenza. **Dosage and administration:** *Adults and children, 12 years and over:* Two capsules/tablets up to four times daily. Do not repeat at intervals of less than 4 hours. Not more than 8 capsules/tablets in 24 hours. *Children under 12 years:* Not recommended. Soluble tablets must be dissolved in water before taking. Do not exceed the stated dose. Do not take for more than 3 days without consulting a doctor. **Contraindications:** Known hypersensitivity to ingredients. **Precautions:** Use with caution in patients with severe renal or severe hepatic impairment, non-cirrhotic alcoholic liver disease. Caution required in patients taking warfarin or other coumarin anticoagulants, domperidone, metoclopramide, colestyramine, monoamine-oxidase inhibitors. Not to be taken concurrently with other paracetamol-containing products. Avoid in pregnancy unless advised by a doctor. Not contraindicated in breast feeding. Sufferers from persistent headache should consult a doctor. Solpadeine Plus Soluble: tablet contains 427 mg of sodium – caution with salt restricted diet. **Side effects:** Paracetamol: rarely, hypersensitivity including skin rash; very rarely, reports of blood dyscrasias (not necessarily causally related). Codeine: constipation, nausea, dizziness and drowsiness. **Overdosage:** Immediate medical advice should be sought in the event of an overdosage, even if the patient feels well, because of the risk of delayed, serious liver damage. **Legal category:** PCDI. **Product licence number:** Capsules: 00071/0186, Soluble Tablets: 00071/5091R, Tablets: 00071/0396. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** 16 capsules £2.99, 32 capsules £4.99; 16 soluble £2.99, 32 soluble £4.99; 16 tablets £2.99, 32 tablets £4.99. **Date of last revision:** June 2006. Solpadeine is a registered trade mark of the GlaxoSmithKline group of companies.

Ask your Pharmacist first

gsk GlaxoSmithKline Consumer Healthcare

The Power of 3 is only available in pharmacy

First Response upgrade

An improved version of the First Response early result pregnancy test has been launched. The product claims to detect the pregnancy hormone hCG up to six days before a period is due.



The packaging has been redesigned to show First Response's benefits. It uses vivid colours for strong shelf presence.

Television and PR activity is supporting the updated product.

Product info:
Church & Dwight
Tel: 01303 858700
www.churchdwight.co.uk

C+D retailing bulletin

Did you miss this month's retailing bulletin on Men's health, with top tips on selling more men's products and trends in the male grooming market?

Ensure you don't miss out again by signing up for future email newsletters at www.chemistanddruggist.co.uk/register

New-look Calmurid

Dry skin treatment Calmurid cream has been relaunched. The P medicine's new-look packaging is designed to be consumer friendly, eyecatching and modern. New packs will go on shelf in July.

Product info:
Galderma
Tel: 01923 208950
www.dryskin-uk.co.uk

Calmurid contains urea (10 per cent w/w) and lactic acid (5 per cent w/w).

The non-greasy formulation is suitable for all ages for the treatment of dry skin conditions including ichthyosis. It should be applied twice daily.



It's a joint effort

Javelin thrower Steve Backley is the new face of jointcare brand Lubramine. Steve, who won medals at three consecutive Olympic Games, is endorsing the product in marketing and PR activity. He will also figure on the brand's website and in the Goldshield catalogue.

Now retired from professional athletics, Steve was diagnosed with osteoarthritis in his early 30s and has undergone a hip replacement. He says he uses Lubramine to help prevent further problems.

Lubramine contains celadrin, a blend of fatty acids. It is available as capsules both with and without glucosamine, and as a cream.

Steve is pictured below right with Ben van Pelt, who is unit head for Goldshield Consumer Health Direct.



Product info:
Goldshield
Tel: 020 8649 8500
www.lubramine.com

Products in brief

Boom time for H&B

Health and beauty is forecast to be the fastest growing retail sector in 2008, says retail information company Verdict Research. Male shoppers entering the market and women's desire for youthful looks are fuelling the growth, says the company. In 2007 consumer spending on health and beauty products rose 4.7 per cent to £15.6 billion. This year men's toiletries are predicted to grow by more than 7 per cent. Alliance Boots came top in 2007 with 25.9 per cent of sales, says Verdict.

Cool tool

A new fridge thermometer – the ETI 810-200 – from Electronic Temperature Instruments has two remote, waterproof temperature sensors to monitor two areas at once and an AV alarm to alert to variations in temperature. Price: £14 + VAT, ETI; tel: 01903 202151; sales@etiltd.co.uk

Products advertised on TV next week

Aquafresh: All areas
Benadryl Allergy Relief: All areas
Bepanthen: All areas
Canesten: All areas
Compeed Blister Plasters: STV, U, C, Y, W, LWT, C4, five, GMTV, Sat
Corsodyl Daily: All areas
Curanail: GMTV, C4, Sat
Feminax Ultra: All areas
Formoline: GMTV, five, Sat
Frontline Spot On: GMTV, five, Sat, W
Lamisil Once: All areas
PerspireX: Sat
Scholl Cracked Heel Repair Cream: All areas except CTV, LWT, CAR
Scholl Nail Brightening System: All areas
Sensodyne: All areas
Syndol: All areas
PharmaSite for next week: Bazuka – windows, **Bazuka** – in-store, **Bazuka** – dispensary
Pharmacy channel: Give it up!, Clearly Herbal

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

MUR ZONE
C+D MUR Zone
Everything you need to know about setting up and carrying out MURs, plus tips for all your consultations
Visit www.chemistanddruggist.co.uk/murzone or see p30

HOW TO...

Advertise your pharmacy

In this step by step guide, **Paul Clapham** demystifies the process of advertising your pharmacy services

Being in business without advertising is like winking at a pretty girl in the dark. You know what you're doing and why, but nobody else does. True – but so is the cynic's response: making a small fortune with advertising is easy – just start with a large fortune. Getting it wrong is likely to produce negative results as bad as doing nothing.

Fail to plan, plan to fail

Start by deciding what you want to say, not the media you plan to use (a common error). Give yourself a plan. It shouldn't be too restrictive, but you should have in place a range of ideas, products and issues to address during the year. Some of these are obvious – hayfever, national no smoking day, new year's resolutions of all types, the coughs and sneezes season, summer travel. Others are less apparent: Wimbledon fills every tennis court in the country for a month, resulting in some middle-aged muscle strains.

Opportunity! Ask all your regular suppliers for ideas on this front – they may have some excellent success stories to tell from around the UK.

Incidentally, some of these ideas may point you to the right media. Drive-time radio could be right for products helping eye-strain.

Next you've got to define your customer base and their geographical location. Be as specific as you can. Are they young, old, rich, poor, home-owners, car-owners, married, single, parents, students, working, retired? Go deeper if you can: are they sports fans, keep fit enthusiasts, telly addicts, gardeners, pubbers, clubbers, computer gamers?

Location, location, location

Location is easier, varying from one town, through a region to national and international. Note that while you might sell regionally or nationally, starting close to home is wiser. Again be as specific as possible. Target customers in as narrow an area as you can – down to postcode areas if appropriate.

The purpose of all this is to help you match your customer profile with the media owners' reader/audience profile. Any good media, from posters to TV to newspapers, should have some very exact details about their audience. You have every right to be suspicious of statistics unsupported by hard researched evidence. The extent of their match to your needs gives you a negotiating position.



Choosing a paper

So what are the serious options for the small/medium sized business? Let's start with the local press: evening dailies, morning dailies, weeklies and free sheets. Since there are some 2,500 around the country, there are local newspapers that will reach your geographical target. But does their readership profile match your customer profile? Ask them for a media pack.

This will tell you the number of copies sold (circulation) and a breakdown of the readership by age, sex and demographics. The better ones also tell you about personal interests, purchasing habits and such details as home/car/computer ownership.

Since most businesses have more than one publication covering their target area, with a bit of diligent number crunching you can establish which paper delivers most of the people you want at the best price. However, it's not just a numerical exercise.

Local newspapers vary in quality quite dramatically. Some are modern, buzzy, vibrant, a key part of the local community, just the environment you want for your business, in fact. Others I wouldn't wrap chips in. This applies to dailies and weeklies alike.

As a rule of thumb, evening dailies have a middle tending to down-market readership. Morning dailies are few in number and have an upmarket business-orientated readership, weeklies have loyal but ageing readers.

Case study: from national to local

Let's look at Numark's experience. As the largest 'virtual chain' of independent pharmacists in the UK, it has moved from national TV advertising to more local support for members. As trade marketing director Lynne Henshaw says, they wanted to promote the localness and independence of Numark pharmacies. "Given the imminent electronic transfer of prescriptions, the need to differentiate the independent pharmacy from the competition and raise the profile locally has never been greater."

Ms Henshaw's recommendations are to aim to do something different from your competitors, especially the multiples that are constrained by national structures and lack reactivity. Tailor your services to the local demographic. Could you, I wonder, use local dialect and terms for illnesses in your ads? "The pharmacy that speaks the local language."

Ms Henshaw also recommends that the pharmacist should get away from doing the jobs that don't require pharmacist expertise, eg sourcing best prices on drugs, and use the time instead to truly engage with local customers.

Numark's experience is that promoting local community credentials is a very powerful message. Many independents are family businesses that have known their customers and their families for years. Contrast that with multiples where the pharmacist can often be a locum. People prefer to see the same doctor regularly and the same applies to pharmacists: "Ask Mr Smith for advice" is far stronger than "talk to our pharmacist" and it's a message you can advertise.

Numark has also found that creating events and then publicising them is highly effective. Examples include a bone density scanning day and an asthma clinic day. One of its pharmacies in Middlesbrough has bought itself roll-up stands to use around the local community.

Free sheets are a different issue. On the face of it they look like good value. They're delivered to the home in a very defined geographical area and are read as much for their advertising as the editorial which is sparse. But are they delivered? Particularly in the more affluent areas, publishers have great difficulty recruiting deliverers. Check with friends and family if they receive the paper and when – if it turns up on Saturday afternoon (rather than by Thursday evening as it should), you've lost some key selling days.

Get down to the nitty gritty

But what do you actually do? I would recommend being a regular advertiser, but avoid being dull. The same general message every week isn't going to work, nor will it fit with focusing on specific opportunities (see above). I recommend buying premium positions (front page if it's available).

Also, look at specialist positions for specific groups. For instance, the beginning of the football or rugby season is an ideal time to use the sports pages offering knee bandages, linament etc as a package.

To create an ad, I would always recommend either learning how to do it on your PC or getting a professional designer involved. If you leave it to the newspaper, you may well be disappointed, depending how good their Mac operators are.

As a rule of thumb, the ad should include: a punchy headline, a subhead expanding on that, details of products or services promoted with a relevant image(s), your address, relevant opening times and parking facilities. Two important don'ts: don't try and cram in too much – take more space if you need it, and don't be scared to be brave – an interesting, exciting professional ad gets more business than a dull one.

Independent pharmacies don't have marketing and advertising experts in-house. But their suppliers most definitely do. They also have high-powered advertising agencies. For brand owners who are truly serious about building business with independents, harnessing those resources to help independents has to be a valuable opportunity to exploit. With the benefits of email it is entirely practicable to provide ready artworked template structures and appropriate images and to do it regularly, responding to market opportunities.

Eurax

One Solution



Summer Skin Ailments

Summer time brings outdoor activities, kids playing and exposure of skin. For families, Eurax is a medicine cabinet essential, bringing relief to the itching and skin irritation caused by insect bites and stings, sunburn, heat rash and nettle rash.

- *The No.1 product in the anti-itch market*
- *The only product to contain crotamiton*
- *Helps Stop itching fast*
- *Up to 10 hours relief*

Trust Eurax

for 10 different skin irritations

- Itchy dermatitis
- Dry eczema
- Allergic rashes
- Insect bites & stings
- Hives
- Nettle rash
- Heat rash
- Sunburn
- Chickenpox
- Personal itching



Contains Crotamiton

Legal Category: GSL
For more information contact the PL holder:
Novartis Consumer Health, Horsham, RH12 5AB.

NOVARTIS

The pre-reg exam

Alan Nathan offers guidance on calculations in the RPSGB registration examination

One of the most important skills of a pharmacist is performing calculations, necessary not only for working out doses and quantities for formulae and dilutions but, particularly in hospitals, performing or checking calculations for doctors and nurses administering medicines, and carrying out pharmacokinetic calculations.

To help ensure that pharmacists are competent for these tasks, calculations form part of the RPSGB's registration examination. A brief explanation of the exam and the question formats, plus some sample questions, are provided in this article. It is hoped that it will give an idea of what the exam is like to pharmacists who qualified before the registration examination began some 15 years ago, as well as providing a little extra practice for pre-registration trainees ahead of their exam at the end of this month.

Structure of the examination

The examination consists of two multiple choice question (MCQ) papers, taken on the same day. The first, in the morning, is a 'closed book' paper (ie no reference materials are allowed), and contains 90 questions to be answered in 90 minutes.

The second, in the afternoon, is an 'open book' paper for which candidates may use the BNF, Drug Tariff and Medicines, Ethics and Practice and the Professional Standards and Guidance Documents booklet that accompanies it, as references.

This paper contains 80 questions to be answered in 150 minutes, and includes a 20-question section of calculation questions, to be done without calculators.

Structure of the questions

Four types of question are used; all require one correct option to be selected from five possibilities.

1. Simple completion

A question is followed by five suggested answers (A to E) from which the correct one must be selected.

Questions

All the necessary information to answer the questions is included within them. The five questions should be answered, without a calculator, within 10 minutes.

1. Simple completion

You are asked to prepare 250ml of a solution of potassium permanganate such that 10ml diluted to 1 litre will give a 1 in 10,000 solution. How much potassium permanganate do you require?

A. 2.5g
B. 10g
C. 25g
D. 100g
E. 250g

2. Multiple completion

A woman with eclampsia has been prescribed an intravenous infusion of magnesium sulphate. Below is an extract from her prescription:

"Magnesium sulphate 20% in 250ml sodium chloride 0.9%.
A loading dose of 4g magnesium sulphate to be given over 10 minutes, followed by 1g every hour."

A nurse asks you to check her calculations. Which of the following is/are correct?

1. To give 4g of magnesium ions over 10 minutes, the infusion rate should be set at 120ml/hr
2. To give 1g of magnesium ions every hour the infusion rate should be set at 30ml/hr
3. The first 250ml infusion bag should last for a maximum of 4 hours 30 minutes

3. Classification (For reasons of space, only one of the three questions that would normally be set is given here)

Possible answers:
A. 0.02g
B. 0.2g
C. 2g
D. 20g
E. 200g

Select from A to E. Which one of the above is the correct quantity to prepare?

1. 200ml of a 1 in 1,000 solution of chlorhexidine gluconate

Worked answers

1. Simple completion

Directions: Each of the questions in this section is followed by five suggested answers. Select the best answer in each case.

You are asked to prepare 250ml of a solution of potassium permanganate such that 10ml diluted to 1 litre will give a 1 in 10,000 solution. How much potassium permanganate do you require?

A. 2.5g ✓
B. 10g ✗
C. 25g ✗
D. 100g ✗
E. 250g ✗

Have to prepare a concentrated solution that the patient will dilute before use. 'Dilution factor' = 10ml → 1litre = 10ml → 1,000ml = 100
Therefore strength of concentrated solution = 1 in 10,000 x 100 = 1/10,000 x 100 = 1/100 = 1g in 100ml
Therefore for 250ml, need 250/100 x 1 = 2.5g

2. Multiple completion

A woman with eclampsia has been prescribed an intravenous infusion of magnesium sulphate. Below is an extract from her prescription:
"Magnesium sulphate 20% in 250ml sodium chloride 0.9%.
A loading dose of 4g magnesium sulphate to be given over 10 minutes, followed by 1g every hour."

A nurse asks you to check her calculations. Which of the following is/are correct?

1. To give 4g of magnesium ions over 10 minutes, the infusion rate should be set at 120ml/hr ✓
Concentration of magnesium sulphate = 20% = 20g in 100ml
To give 4g (in 10 mins), volume required = 4/20 x 100 =20ml
20ml in 10mins = 20 x 6 = **120ml/hr**

2. To give 1g of magnesium ions every hour the infusion rate should be set at 10ml/hr ✗
To give 1g (in 1 hr), volume required = 1/20 x 100 = **5ml/hr**

3. The first 250ml infusion bag should last for a maximum of 4 hours 30 minutes ✗
250ml bag contains 2.5 x 20 = 50g magnesium sulphate
Infusion rate = 4g in 10 mins, then 1g/hr
After 10 mins bag contains:
50 - 4 = 46g
46g @ 1g/hr = 46 hours
Therefore contents of bag will last **46 hours 10 mins**

Key = D (*1 only correct*)

3. Classification

Directions: Each group of questions below consists of five lettered headings followed by a list of numbered questions. For each numbered question select the one heading which is most closely related to it. Each heading may be used once, more than once, or not at all.

A. 0.02g
B. 0.2g
C. 2g
D. 20g
E. 200g

Select from A to E. Which one of the above is the correct quantity to prepare?

1. 200ml of a 1 in 1,000 solution of chlorhexidine gluconate

1 in 1,000 = 1g in 1,000ml
Therefore in 200ml = 200/1,000 = 1/5 = 0.2g
Key = B

2. Multiple completion
A question or statement is followed by three options, numbered 1-3, one or more of which is or are correct. Candidates must choose if:
• 1, 2 and 3 are correct (answer A)
• 1 and 2 only are correct (B)
• 2 and 3 only are correct (C)
• 1 only is correct (D)
• 3 only is correct (E)
(Options 1 and 3 only and 2 only cannot be correct answers)

3. Classification
These are groups of between two and four questions, consisting of three to five lettered headings (A,B,C etc) followed by a list of two to four numbered questions (most often five headings followed by three questions). For each numbered question, the one heading that is most closely related to it must be selected. Each heading may be used once, more than once, or not at all.

4. Assertion/reason
Questions consist of a statement in the left hand column of the page followed by a second statement in the right hand column. The candidate must decide whether the statements are true or false and then choose:
• If both statements are true and the second statement is a correct explanation of the first statement (ie if both can be linked with "because") (Answer A)
• If both statements are true but the second statement is not a correct explanation of the first statement (B)
• If the first statement is true but the second statement is false (C)
• If the first statement is false but the second statement is true (D)
• If both statements are false (E)

Alan Nathan is a former member of the RPSGB's registration examination board

2. 2 litres of a 0.01% solution of chlorhexidine gluconate

4. Assertion/reason
A local GP occasionally writes prescriptions for Gentian Mixture, Alkaline BP. You keep all the ingredients in stock and make up the mixture extemporaneously in response to individual prescriptions. You receive a prescription for 500ml of the mixture. The formula requires 5ml of double-strength chloroform water per 10ml dose. You do not keep double-strength chloroform water but use concentrated chloroform water instead. (Chloroform water contains 0.25% chloroform. Concentrated chloroform water contains 10ml chloroform/100ml.)

First statement: You need 50ml of concentrated chloroform water for 500ml of Gentian Mixture, Alkaline BP.
Second statement: Concentrated chloroform water is 20 times stronger than double-strength chloroform water.

2. 2 litres of a 0.01% solution of chlorhexidine gluconate
0.01% = 0.01g in 100ml
Therefore for 2 litres, require 2,000/100 x 0.01 = 20 x 0.01 = 0.2g
Key = B

4. Assertion/reason
A local GP occasionally writes prescriptions for Gentian Mixture, Alkaline BP. You keep all the ingredients in stock and make up the mixture extemporaneously in response to individual prescriptions. You receive a prescription for 500ml of the mixture. The formula requires 5ml of double-strength chloroform water per 10ml dose. You do not keep double-strength chloroform water but use concentrated chloroform water instead. (Chloroform water contains 0.25% chloroform. Concentrated chloroform water contains 10ml chloroform/100ml.)
First statement: You need 50ml of concentrated chloroform water for 500ml of Gentian Mixture, Alkaline BP.
Amount of double strength chloroform water required would be: 500 x 5/10 = 250ml. From information given, concentrated chloroform water is 40 times stronger than chloroform water (10%/0.25%), therefore 20 times stronger than double strength chloroform water. Therefore, quantity of concentrated chloroform water required is: 250/20 = ***12.5ml***

Therefore, statement is ***False***

Second statement: Concentrated chloroform water is 20 times stronger than double-strength chloroform water.
True *(see calculation above)*
Key = D



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On the front of your pharmacy there's probably a big green cross. Now the government wants this to be community pharmacy's environment badge of honour. **Rob Finch** finds out why

The Green Cross road



It takes conscious effort to avoid the path of least resistance, but as the government's new Carbon Reduction Strategy (CRS) sets out, we can all make small steps towards the big targets being set out.

Unfortunately, in environmental terms, the health service is performing pretty badly. The stark fact is that as the nation's biggest employer, it is also one of the nation's largest users of energy and resources, with more than 18 million tonnes of carbon dioxide created by NHS activity, accounting for 3 per cent of total UK CO_2 emissions.

A 2004 breakdown of carbon emissions in the NHS showed 18 per cent came from patient and staff travel, 22 per cent from heating and lighting of buildings and 59 per cent from procurement of goods and services, as well as waste disposal. Meanwhile, a more recent study found 22 per cent of NHS carbon emissions came from primary care. The government estimates that, if trends continue, patient and staff travel emissions will rise by 35 per cent by 2030.

But the problem is not just caused by staff or patients, or big hospitals. It is a community pharmacy issue because the largest contribution to the NHS carbon footprint, at 11 million tonnes of CO_2 per year, is due to the supply chain – of which 62 per cent comes from pharmaceuticals.

And unfortunately, because of an ageing population, NHS activities will expand and its environmental impact will grow. The CRS sets out how the socially responsible ethos behind the founding of the NHS could and should apply to tackling this global problem.

Overall, the government is committed to reducing carbon emissions by 60 per cent by 2050 compared with 1990 levels. There has been progress, with the NHS on track to meet its 2010 goal of reducing energy consumption by 15 per cent on 2000 levels. But to support achieving this new target in the health service, a new NHS sustainable development unit (SDU) has been set up that will provide support to health organisations while coming up with new plans of action for the health service.

By reducing carbon emissions, the CRS says the health service can save money that can be ploughed back into patient services. And health minister Ivan Lewis says climate change is one of the greatest threats to health and wellbeing, but tackling it can offer health benefits as well as saving some of the £429 million the NHS currently spends on energy.

As part of this effort, the CRS sets out plans to minimise waste, improve efficiency of buildings and supply, and reduce travel. The strategy is aimed at making NHS providers, including pharmacists, more 'carbon aware' – understanding their carbon footprint and developing plans to reduce it. To further boost sustainable initiatives, the CRS demands PCTs give carbon management equal priority to financial management and patient safety.

It also demands that from 2018 all new NHS buildings have to be entirely carbon neutral, and already this is happening. The recently built Plowright Medical Centre, a dispensing GP practice in Norfolk, has focused on natural lighting and ventilation, enabling it to outstrip the new targets.

Part of the work of the SDU in overseeing the CRS implementation will be to examine carbon emissions from the pharmaceutical supply chain and to work with pharmacies and the industry on how to reduce these. The SDU suggests simple measures such as reducing consumption and boosting efficiency of supply – taking into account the 'whole life' cost of a product at the time of purchase rather than just the initial purchase cost.

The Department of Health has a £100m energy fund to help NHS organisations improve efficiency, and other grants are available from the Carbon Trust. Boots is currently working with the Carbon Trust – which also offers green checklists – about medium term plans to save 10,000 tonnes of carbon and up to £2m.

> "The largest contribution to the NHS footprint is due to the supply chain"

The CRS also suggests promoting walking and cycling to reduce obesity, improve mental wellbeing, improve air quality and cut road accidents. It flags up the possibility of organisations offering the 'Cycle to work' scheme that allows employees to buy bicycles tax-free. Added to this, PCTs are now being asked to collect data on staff, patient and visitor mileage, and the CRS suggests that they should offer staff a 20p mileage rate for cycling to work rather than using their cars.

Pharmacy representatives are already taking a lead, with the NPA (which already has a 'green strategy') pledged to commit to the CRS. Alastair Buxton, head of NHS services for PSNC, believes the green agenda will be business-led rather than being forced on pharmacists. He says: "It is incumbent on any customer-facing business to do the right thing or the public will ask why you're not doing it."

PSNC head of pharmacy practice Barbara Parsons, who has been involved with a DH sustainable development group, thinks pharmacies should be a focal point for acting on climate change, with pharmacists as local leaders: "For pharmacy, they're looking for long-term planning – they have made some efforts in reducing the carbon footprint and want to take that to a personal level into pharmacists' homes and as local employers. "The big thing people can do is to turn off their computers and faxes when they lock up – silly little things but there are economies of scale, especially for the multiples. It's amazing how many people don't shut down at night. Saving carbon saves cash."



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Keep your data secret



A breach of the Data Protection Act could land you with a £5,000 fine and a spell in prison. Andrew Lynas offers a step by step guide to keeping on the right side of the law

When HM Revenue and Customs admitted to losing discs containing details of 25 million child benefit claimants, there was a public outcry. In the wrong hands, the records would provide sophisticated criminals with a valuable tool to steal the identity of millions of innocent victims – to open bank accounts, get credit cards, loans, state benefits and generate passports and driving licences.

In an age where face-to-face transactions are no longer the norm and paper records increasingly obsolete, maintaining confidence in the way personal information is handled is essential best practice in business. Organisations cannot and must not take good security for granted – the stakes are simply too high for getting it wrong. HMRC found this out to its cost. Within hours of the announcement that it had lost child benefit discs there was a massive public outcry, the chairman resigned, questions were asked in Parliament and the Information Commissioner's Office (ICO) commenced formal investigations under the Data Protection Act 1998.

Here we explore the importance of managing personal information properly, outlining the legal responsibilities organisations have to protect personal information, the consequences of failing to comply with those responsibilities and practical steps that can avoid some of the most damaging pitfalls.

Taking care of personal information

The well publicised problems suffered by HMRC highlight the risks of failing to properly protect personal information. Sadly, the case is not unique. Earlier in the year, Nationwide Building Society was fined a record £1 million for failing to take proper steps when a laptop containing 11 million customer records was stolen from an employee's car and a further 11 banks and building societies were 'named and shamed' for the reckless way in which they discarded customer records on the high street.

These incidents damage confidence, erode hard won reputations and ultimately lose businesses money.

Taking proper care of personal information is not just sound commercial practice, it is a legal requirement. Any organisation responsible for the collection and use of personal information must comply with the Data Protection Act 1998. The DPA establishes a legal framework which 'data controllers' must follow when 'processing' personal information.

All data controllers have a duty to keep personal information within their control secure against unauthorised or unlawful use. This is a specific requirement within the DPA and requires organisations to ensure that:

- personal information is held within secure IT systems.
- appropriate physical and technical controls are in place to limit access to personal information held within the organisation on a 'need to know' basis.
- personnel who have access to personal information are subject to appropriate security vetting and confidentiality agreements.
- everyone within the organisation is aware of the role they have in managing information security.
- policies and procedures are in place to manage security risk and effectively deal with any security breaches.
- penetration tests and audits are regularly carried out to validate and enhance these procedures.
- where personal information is provided to a third party (for example, to a payroll provider), a security risk assessment is carried out on that organisation before any personal information is handed over and the basis on which the information will be used is clearly delineated in a 'data processor' contract.

Information security is only one aspect of the legal responsibilities set out in the DPA. The legislation also sets out broad responsibilities to manage personal information in a fair and lawful manner. Compliance with these additional requirements means:

- formally notifying the ICO about the types of personal information collected and used by the organisation. This notification is published in a public register of 'data controllers'.
- issuing 'privacy policies' to staff, customers etc that explain in clear English the personal information held by the organisation and how this is used.
- only using personal information for purposes which are 'fair' in all the circumstances, having regard for the individual's expectation of privacy. It will generally only be fair to use personal information:
  - to fulfil a legitimate business activity which does not harm the individual (for example, to fulfil a specific transaction with the individual),
  - to comply with a specific legal responsibility (for example, to pay National Insurance contributions), **or**
  - where the individual has specifically authorised their information to be used in a particular way (for example, where they ask for their details to be passed to another company).
- ensuring the purpose for which information is to be used is clearly explained to the individual in the relevant privacy policy and justifiable on one of the above mentioned grounds. It is often tempting to use information collected for one purpose at one time, for something else later on, or to pass it on to a third party. This may not be possible – so always confirm what is permissible before authorising such activity.
- limiting the amount of personal information used to fulfil a particular activity to the data actually necessary to complete that task.
- taking care to update records that become out of date or obsolete.
- allowing individuals the right to access a copy of the personal information held by the organisation on demand.
- allowing individuals the right to 'opt out' from any direct marketing activity.
- not transferring any personal information outside the European Economic Area without securing additional protections.

Enforcement under the DPA

The ICO regulates compliance with the DPA. It is required to investigate and rule on complaints received from members of the public on alleged breaches of the legislation and wields significant power to carry out formal inquiries and enforcement action.

Organisations which are investigated by the ICO are likely to be exposed to adverse publicity once those investigations are complete – the ICO has a deliberate policy of raising awareness of data protection through publicising poor working practices. If systemic failures are identified, there is also a risk of being fined up to £5,000 in a magistrates court or unlimited in a Crown court.

Further, if individual members of staff are found to be involved in making unauthorised disclosures of personal information they personally face the prospect (following recent changes to the Criminal Justice and Immigration Bill) of a custodial sentence.

Information compliance

Establishing a clear regime of information governance will ensure compliance with the rules and limit the risk of things going wrong.

As a basic checkpoint, make sure these simple processes are in place:

- Have a clear understanding about the personal information collected and used within the organisation.
- Ensure the way in which personal information is used remains consistent with the expectation of the individuals concerned – be satisfied that staff, customers etc would not be surprised to learn about the way in which their private details are used.
- Have a data retention policy that ensures records are regularly updated and (when obsolete) deleted.
- Have a security policy that sets out a clear process for maintaining the integrity of data, prevents unauthorised access to information and has an effective procedure for managing breaches.
- Ensure IT infrastructure supports effective security controls and data management.
- Carry out regular data protection compliance audits.
- Nominate a senior person with overall responsibility for management of data protection and security compliance. This individual should have a direct reporting line to board level (if approriate).

When things go wrong

If an information security breach occurs, the temptation may be to keep quiet and hope it passes unnoticed. This is usually a recipe for more trouble. The ICO is quite clear that if things go wrong there is an overriding duty to protect the individuals' concerned as quickly and effectively as possible. At a minimum, this is likely to mean issuing a clear communication to those affected explaining what has happened; explaining risks they may be exposed to as a result – for example, any enhanced risk of identity theft and steps to minimise that risk; notifying the ICO, so it can provide appropriate additional advice and guidance; carrying out immediate remedial action to prevent a recurrence; and conducting an investigation to understand any systemic organisational failures that should be rectified.



> "Organisations cannot and must not take good security for granted – the stakes are simply too high for getting it wrong"

For the future

The ICO has just been given the power to audit and inspect those government organisations that hold and process personal information without first having to gain permission. Similar powers are being sought for businesses.

Further, s55 of the DPA relates to the illegal buying and selling of personal information. Presently it carries a criminal penalty of up to £5,000 in a magistrates court or an unlimited fine in a Crown court. But going through Parliament as part of the Criminal Justice and Immigration Bill is a proposal to add a two-year prison sentence. Also, the ICO wants reckless breaches of the Act to become a criminal offence. Only s55 breaches and breaches of an enforcement notices are criminal offences under the present law.

Conclusions

People expect their personal information to be properly protected at all times, whether held by the public or private sector. Organisations that fail to put in place appropriate measures to secure information risk alienating their customers, upsetting regulators and undermining their commercial viability. These risks are real and substantive. If not already in place, commit now the appropriate resource and attention needed to ensure secure effective information governance.

Andrew Dyson is a partner in DLA Piper, specialising in information law and data protection (andrew.dyson@dlapiper.com).

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MHRA guidance on licences

The MHRA is advising that licences granted pursuant to the Medicines Act 1968, as amended, for the purpose of the wholesale distribution or the manufacture/ assembly and/or import of medicines for human use, cannot be transferred by the holder to another legal entity. Holders of such a licence, who are planning to sell their business, should not offer their licence for sale as a part of that business.

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postScript

What have you and your team been up to lately? Let us know and send us your photos. Email postscript@cmpmedica.com

On her bike



A Co-operative Pharmacy employee has cycled from Essex to Amsterdam to raise money for charity.

Communications manager Lucy Verlander completed the 185-mile trek from Stansted to the Dutch capital with her brother and a friend.

She said: "I've done the London Marathon before, but it's the first time I've done such a long bike ride. I didn't even have a bike – I've had to borrow one from my brother!"

Lucy and her team hope their achievement will raise more than £1,000 for the Breast Cancer Haven Charity. They can be sponsored at www.justgiving.com/amsterdamned.

Web comment of the week

Demand for referendum on Society future dropped Posted by Graham Phillips, on 29/05/2008 19:47

"It is **very disappointing** to see some members attempting to **deny the wider membership** their right to be consulted. **How many members** will 'our' new professional body have if **the grassroots feel** we've been **excluded** from all the decisions?"

Have your say on C+D's website register for free at www.chemistanddruggist.co.uk

Fertility fame

Pharmacists offering even basic advice on fertility could be competing for their patients' attention against some unlikely sources of information.

A study of 1,000 people by Clearblue found that almost a quarter (23 per cent) may have actively changed their plans to start a family because they had been influenced by high profile celebrities' struggles to conceive. Eighty two per cent said such struggles had highlighted the reduced chances older women have of conceiving naturally, and over a third had reconsidered their own fertility timeline as a result.

The news came in the same week the Guardian reported that the head of the Human Fertilisation and Embryology Authority had called for information about infertility, as well as on avoiding pregnancy, to be given by schools.



Boom time ads



A seven ton truck filled with equipment and explosives and cameras set up behind bullet-proof glass are not things you would usually associate with pharmacy. But while the new pharmacy posters for GSK's Solpadeine Plus might take a second to put up, more effort certainly went into making them.

The ad agency Ogilvy used an explosive visual to show how the drug can obliterate pain". However, filming for the poster involved a team of experts including a fire worker and special effects professional. It took around 40 detonations to get the desired effect, with the camera capturing the explosion a nanosecond after detonation.

Moving on



Alliance has appointed Raj Haria as director of sales and business development. The buying group created the role, which will include strengthening member services and facilitating business partnerships, to accommodate its expansion plans. Mr Haria joins from Nucare



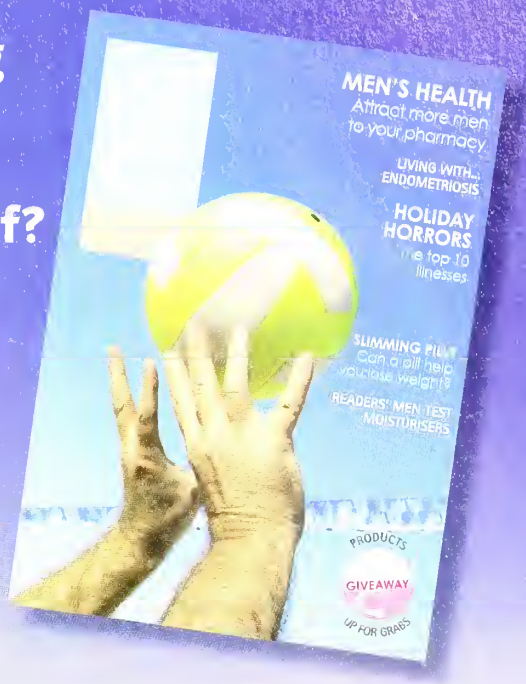
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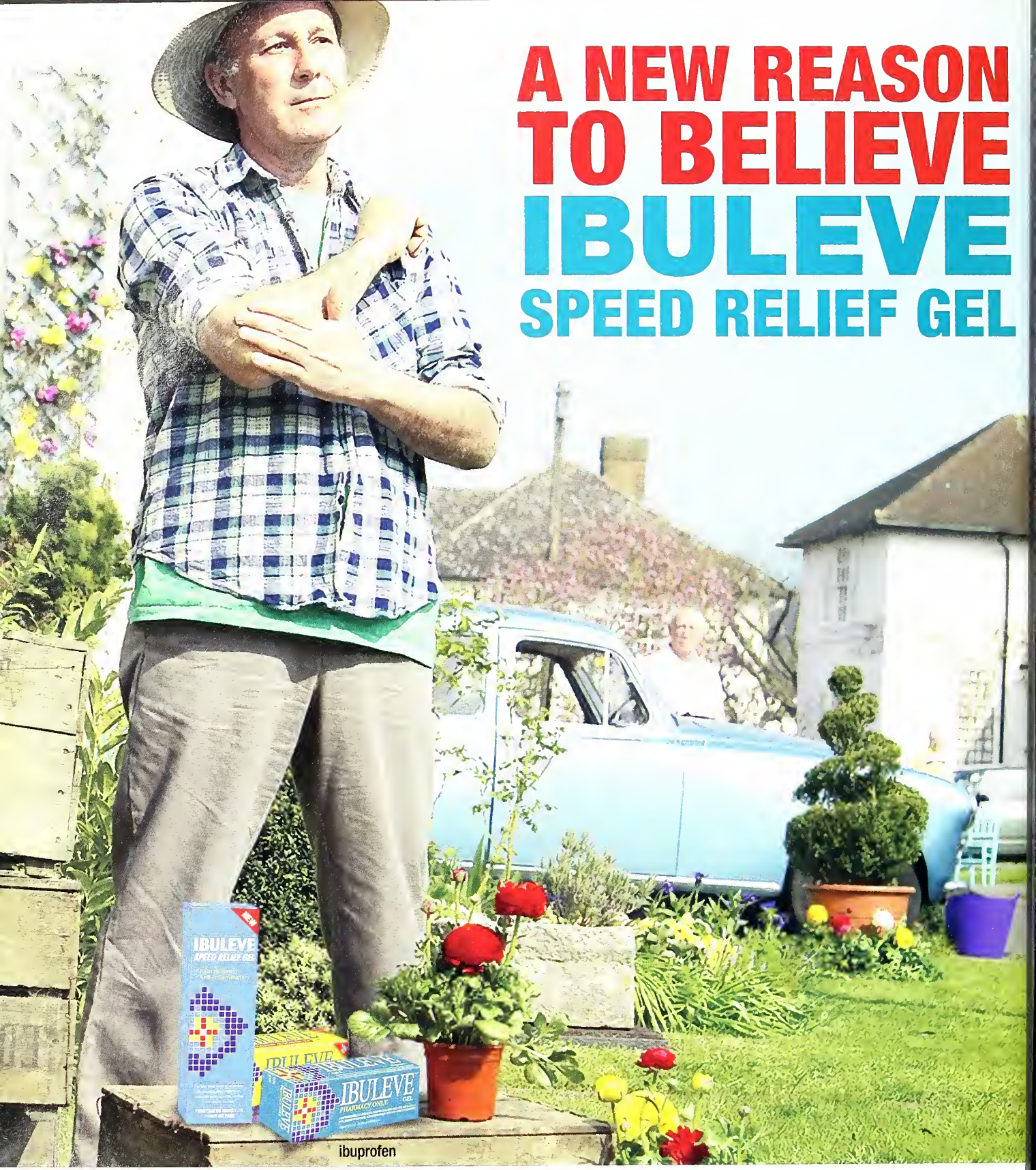
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New Ibuleve Speed Relief Gel is available from:

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IBULEVE Trademark and Product Licence held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Indications:** Ibuleve Gel and Maximum Strength: For the relief of backache, rheumatic and muscular pain, sprains and strains. Also for pain relief in non-serious arthritic conditions. **Ibuleve Speed Relief Gel:** For fast local relief of rheumatic pain, muscular aches, pains or swellings, such as strains, sprains and sports injuries. **Directions (Ibuleve Gel):** Lightly apply a thin layer of the gel over the affected area. Massage gently until absorbed. Wash hands after use. Repeat as required up to three times daily. **Directions (Ibuleve Maximum Strength Gel):** Lightly apply 2 to 5 cm of gel (50 to 125 mg ibuprofen) to the affected area. Massage gently until absorbed. Wash hands after use. Repeat as required up to three times daily. **Directions (Ibuleve Speed Relief Gel):** Lightly apply 4-10cm of gel over the affected area. Massage gently until absorbed. Wash hands after use. Repeat as required up to three times daily, at least 4 hours apart. **Contraindications:** Not to be used if allergic to any of the ingredients, or in cases of hypersensitivity to aspirin, ibuprofen or related painkillers, especially where associated with a history of asthma, rhinitis or urticaria. Not to be used on broken skin, under occlusive dressings (Ibuleve Speed Relief Gel only) or where there is infection or other skin disease. Not to be used during pregnancy or lactation. **Precautions:** Not recommended for children under 12 years without medical advice. If symptoms worsen or persist, consult a doctor or pharmacist. Patients with asthma, an active peptic ulcer or a history of kidney problems should consult their doctor before use, as should patients already taking aspirin or other painkillers. Interaction with blood pressure lowering drugs may occur, but is very unlikely. Keep away from the eyes, nose and mouth. Keep all medicines out of the reach of children. For external use only. **Side-effects:** In normal use, side-effects are very rare, but may occasionally include hypersensitivity reactions, and in susceptible individuals renal and/or gastrointestinal side effects. **Legal category:** P Ibuleve Gel and Maximum Strength Gel; GSL Ibuleve Speed Relief Gel. **Packs:** Ibuleve Gel (PL 0173/0060) - 30g, RSP £3.89 (£3.31 exc. VAT) and 50g, RSP £5.39 (£4.59 exc. VAT), Ibuleve Maximum Strength Gel (PL 0173/0176) – 30 g, RSP £4.95 (£4.21 exc VAT) and 50 g, RSP £6.95 (£5.91 exc. VAT), Ibuleve Speed Relief Gel (PL 0173/0060) – 40g, RSP £5.60 (£4.77 exc. VAT). **Revision date:** July 2003